Oral Hygiene

CEMBER 1948

In This Issue:

PREVENTIVE AND PROTECTIVE DENTAL MAINTENANCE

A COMPLETE TABLE OF CONTENTS APPEARS ON PAGE 1911

To Eliminate Costly and Annoying Repairs—

HANDPIECES *should first be cleaned with*

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No single preparation can both clean and lubricate. To insure the greatest possible service from handpieces and angles clean off accumulations of grit and dirt regularly with SOLUBRI CLEANER.

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which keeps handpieces and angles running smoothly and prevents rust. Takes but a moment and protects all moving parts against undue wear.

Wide mouth 2 ounce bottles $.50 each
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YOU NEED NOT be concerned about retention in immediate dentures. A denture can be worn immediately after surgery with perfect retention, and without pain or discomfort, if it is lined with Konformax Rebase.

A lining of Konformax Rebase in a denture acts as a "cushion" that is very comforting to the patient, and also affords antiseptic protection. Such lining lasts from three to six months and can be added to at any time.

Konformax Rebase is equally efficient on partials as on full dentures . . . whether they be Acrylic, Metal or Vulcanite. Literature on request!

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The Publisher's Corner

By Mass **Number 329**

SOME READERS WRITE

HERE'S A LETTER from an old friend of ORAL HYGIENE, Doctor Arthur T. White of Pasadena, California, about the September number. Arthur says he'd been going over the issue from front to back "hunting something to peever about," but didn't find much reason to complain. Even the September CORNER wasn't too bad. And he was particularly taken with Susan Bond's article, "My Dentist Talks Double Talk." You may remember it was about patients like Susan being bewildered by their dentists' vocabularies.

According to Arthur, "Susan may have laid it on a little heavy, but altogether it is a good article and I commend her for it." Susan's article reminded Arthur of one of his pet peeves, "the word *roentgenogram* and all its intricate modifications." He adds: "Good old *x-ray* was good enough for the revered discoverer and it's good enough for me." It's fun printing this quote of Arthur's because the CORNER has been feudin' and fightin' for years with ORAL HYGIENE's editorial department about their use of *roentgenogram*. They just love that word. Ah there, Ed! Ah there, Marcella!

Arthur likes Doctors Smedley and Warner's "Ask ORAL HYGIENE" department; "kind of a post-graduate course every

month." And "Laffodontia," he says, gives him a chuckle or two. Bob Ketterer takes a bow for that job. "I suspect you know some better ones which you do not let them print," Arthur remarks, then sends his "best love to all the staff."

* * *

Bob Kerr, Sr., of Detroit wrote too. Bob said he enjoyed reading Dean Moor's CORNER, "Silver Threads Among the Gold," adding, "Isn't it a great privilege to live a full span of life in this wonderful world and to be able to enjoy every minute and grow old gracefully. I think 'Silver Threads Among the Gold' fits in with Henry Wadsworth Longfellow's 'Psalm of Life.' "

* * *

California again. A little spiel from Doctor Harry Tuckey who's been rusticating in the sunshine at Shallow Creek Farm near Orland. "A few years ago, one of the ranch hands had some dental work to be done, and since the poor devil had no money we decided to have him come down to 'the city.' He'd never been in a 'city'—he had come from somewhere out in the hinterland of Missouri. To save time, I did the surgery; he was shuttled back and forth between two other chaps in the office for other work. On the morning of the second day he ups and says: 'Hey, Doc, when you get to thirty-seven and a half's worth you better let me know!' Of course, we weren't going to charge him anything. Anyway, I thought this would make you laugh until I get something else to bother you about."

* * *

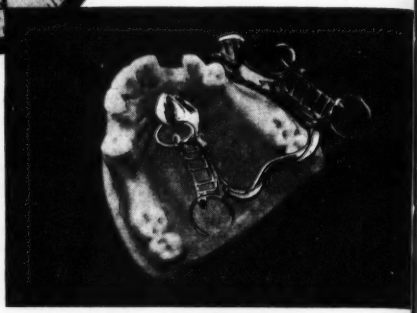
Another letter from California—from my sister Marjory Grubbs of Menlo Park. "If you need a topic for your CORNER, write something about 'The Gentlest Dentist.' " She'd had a tooth go bad, "one that gives you the old anvil chorus, and then

it's merely  *to a testing laboratory*

but it means

patient comfort

to you



To a testing laboratory, Durallium's high performance rating is merely figures taken from a series of tests and expressed in pounds per square inch . . . tensile strength, 112,200 LB./IN² . . . crushing strength, 242,200 . . . elastic limit, 88,000.

To you, Durallium—outstanding chrome-cobalt alloy—has equally technical but more important dental significance in terms of patient comfort. The extra patient comfort is the result of Durallium's resistance to torque . . . its maintenance of original fit even under continuous stress . . . and its resiliency, which reduces strain on abutment teeth.

However, whether mechanically tested in a physics laboratory—and measured in terms of physical symbols—or subject to prolonged clinical use, Durallium offers this all-inclusive advantage: its physical characteristics make for maximum convenience in both preparation and use.

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a jab. Wow! My new dentist had to give me three shots of novocain, and it was the *first* time in my life I never felt the needle. Of course, being me, the tooth broke in four or five pieces and he had to chisel it out. I never have had anyone be so careful; and I had no pain nor after-effects." Marj is telling everybody about it. And that, children, is how practices are built.

* * *

Doctor G. M. Terry down in Jefferson, Texas, scribbled a postal to get his address changed, says he didn't want to miss any issues. "Guess I feel peculiar about a publication that 'graduated' when I did." That was thirty-eight years ago. He promises to send some reminiscences for the CORNER.

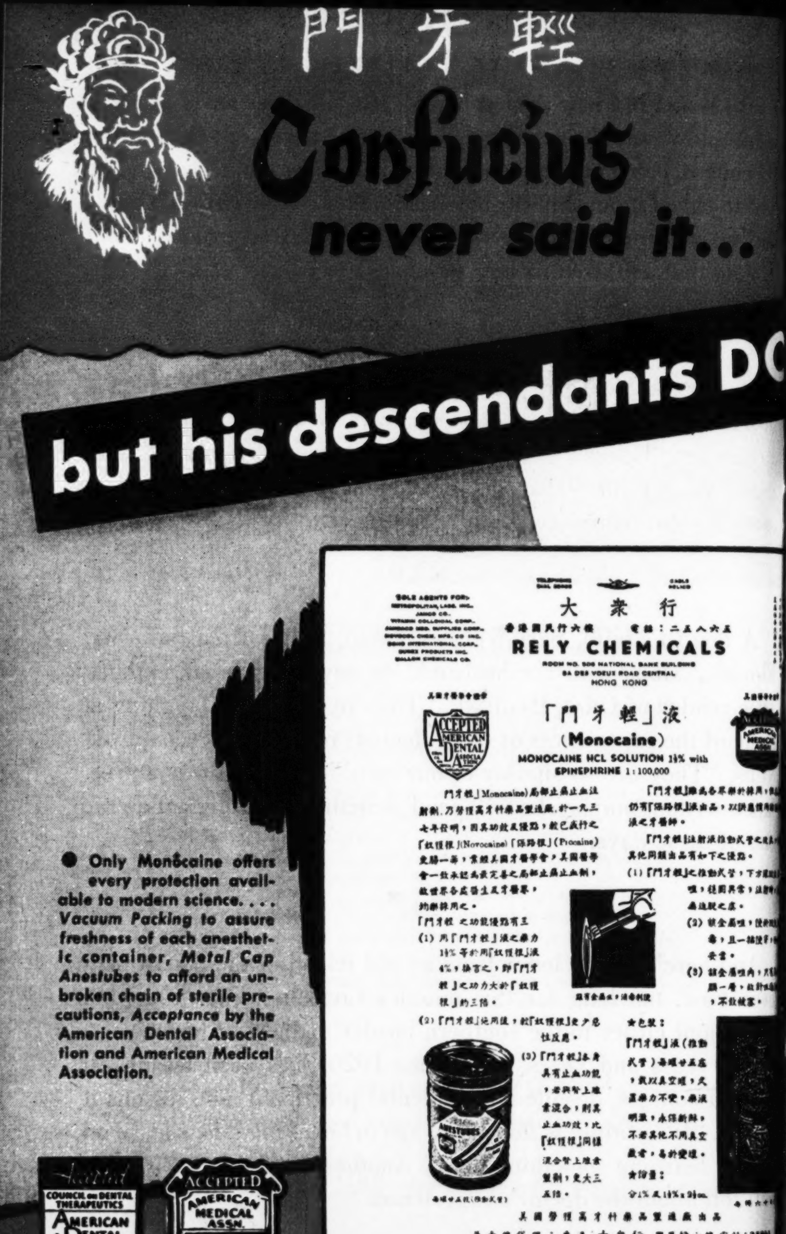
* * *

A dentist's wife, Sari Webster Fabio, writes from Sarasota, Florida. Along with her husband, she says, she is "an enthusiastic reader of ORAL HYGIENE." They've both been laughing at some of the experiences of other dentists reported in recent CORNERS. "They are so similar to our own!" Mrs. Fabio is a free-lance writer; maybe she will send something for this cul-de-sac one of these days.

* * *

And here's a long letter from an old friend of the department over East, too long for this month's CORNER which is getting closer and closer to the southern border of the last page.

For years and years, ever since 1920, he's been taking all sorts of courses, despite a busy dental practice. Piano lessons it is now. "It certainly is fine at my age to be taking a new lease on life by learning something new." Another time, the department will tell about the doctor's experience.



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never said it...
but his descendants DO
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MONOCAINE HCL SOLUTION 1½% with EPINEPHRINE 1:100,000
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GUARD AGAINST PAIN *with* MONŌCAINE

Enigmatic . . . . . exotic . . . . . mysterious China. Weird mixture of the very old and the very new. In the fields, millions of men and women laboriously push their crude plows in the same way their ancestors did more than 5,000 years ago.

But, in the modern hospitals and dental offices —in Shangnai, in Canton, in Peiping, in Chungking—Chinese patients enjoy blessed relief from suffering through the use of *Monōcaine—the modern potent local anesthetic.*

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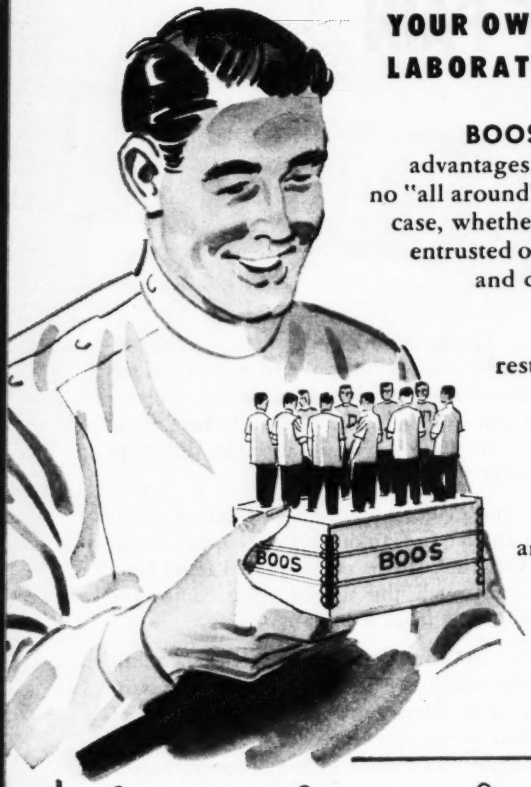

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Supervision by executives with complete understanding of case requirements and Dentists' prescriptions is an integral part of this dependable, capable and complete service.

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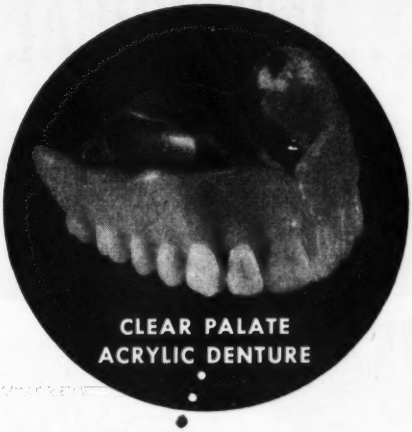

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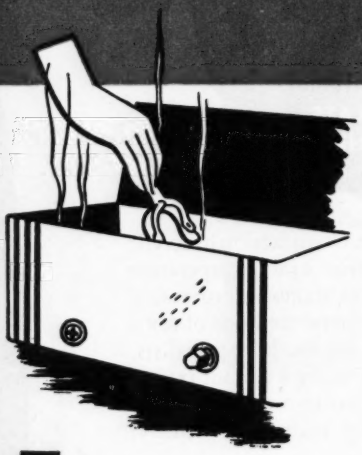
NOW...INDIVIDUAL TRAY
IN YOU



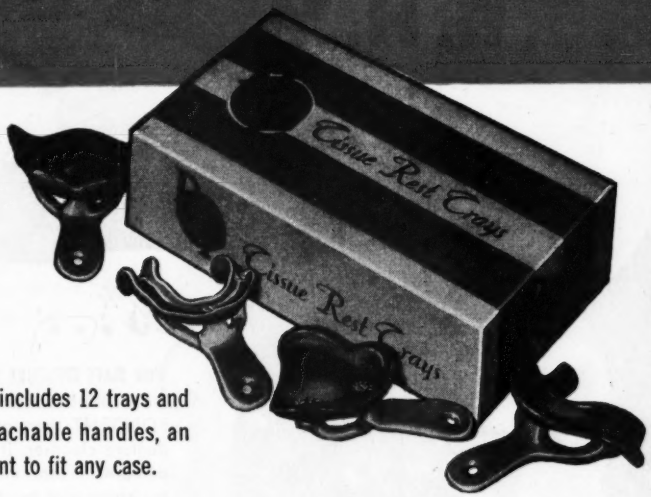
1. Immerse in Hot Water

2. Adapt in the Mouth

INSTEAD OF THE USUAL FIVE STEPS	1 Preliminary Impression	2 Impression Delivered to Laboratory	3 Laboratory Pours a Model	4 Laboratory Makes a Tray	5 Tray Deliv to Yo

N TWO EASY STEPS...

WN OFFICE



Package includes 12 trays and four detachable handles, an assortment to fit any case.

In making full impressions, you can now eliminate one visit by the patient, cut down chair time and do away with three steps that waste time and cost you money . . all by using D-P "Tissue Rest" Trays.

After they are immersed in hot water, "Tissue Rest" Trays can be quickly adapted in the patient's mouth. Easily trimmed or adjusted while warm, they become rigid when chilled.

Intended for any full denture technic using cold materials, "Tissue Rest" Trays are especially designed for D-P Alginate or Three-In-One Cream.

Write for brochure on "Dry Mouth Technic" using alginates. Discover for yourself the simplicity, speed and remarkably accurate results obtainable.

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We will send gladly a generous sample supply for your patients on request. Just write to
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POLIDENT IS THE WORLD'S LARGEST SELLING DENTURE CLEANSER

easy to administer, pleasant to take prompt to act

A balanced saline combination which acts by simple osmosis to dilute fecal residue and produce soft fluid bulk . . .

Stimulates peristalsis and promotes *speedy* but *gentle* evacuation.

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"the Difference can be Distinctive"

For the patient, use of Novocain-Pontocaine-Cobefrin will mean the difference between an appreciated professional service and a very painful experience.

For you, "N.P.C." will mean the difference between a thorough treatment and one hurried and perhaps incomplete, just to spare the patient.

Periodontal treatments are often very painful procedures and in many cases can be carried out more effectively under local anesthesia.

The duration of such treatments also calls for that deep, dense, long-lasting anesthesia which you can best obtain with Novocain-Pontocaine-Cobefrin.

In operative work where pain or discomfort is probable, let your first step be —

Anesthetize with "N.P.C."

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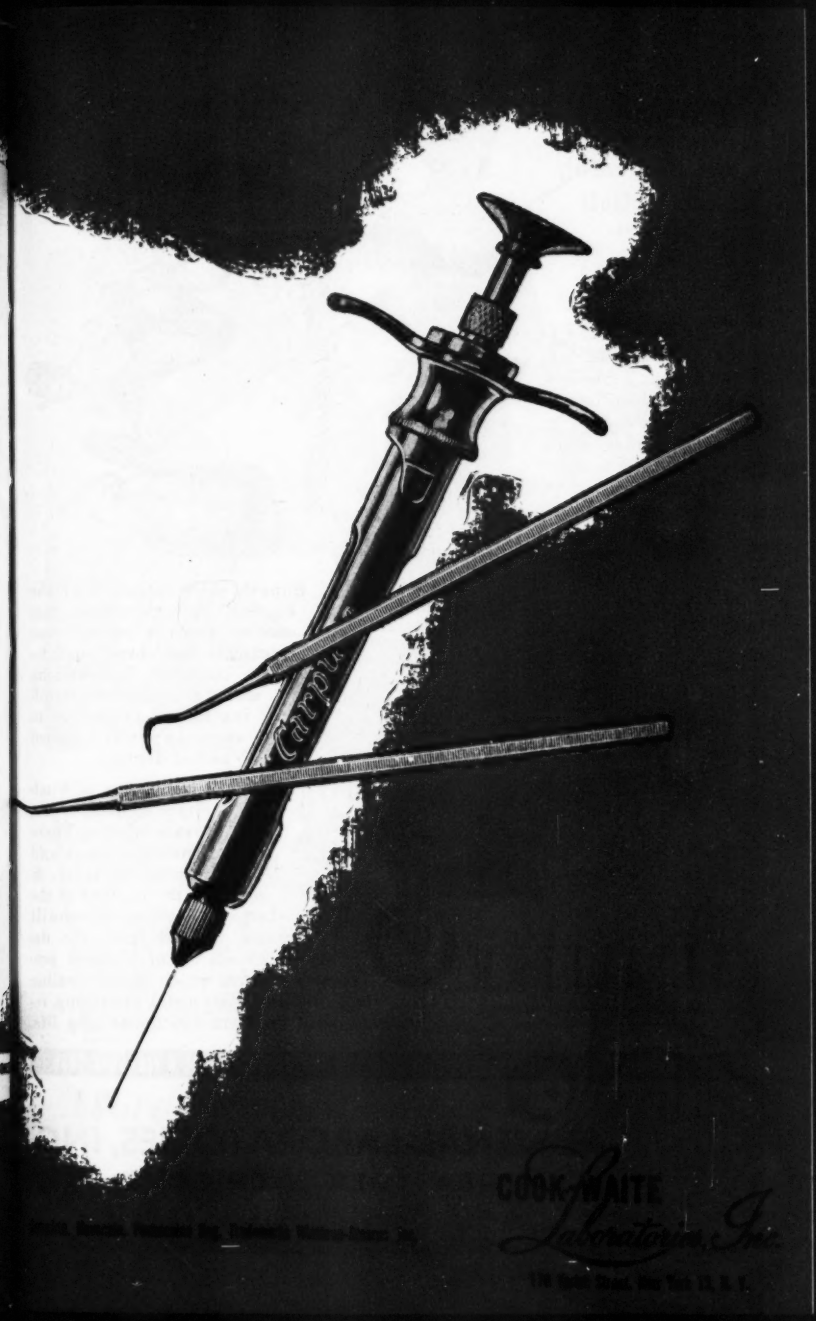
DEEP Anesthesia; LONG-LASTING Anesthesia; WITHOUT ADDED VASOC

Novocain-Pontocaine-Cobefrin



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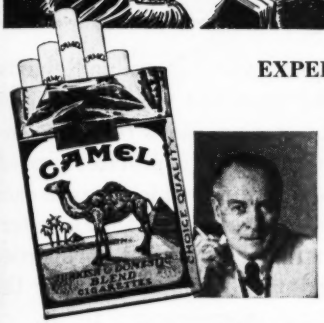
BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. At the same time, other obstetricians were beginning to realize the necessity of greater attention during the ante partum period as a result of their investigations of eclampsia. It remained for Ballantyne, however, to be the first to establish a clinic for the expectant mother.



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Try Camels. See if your *own* taste doesn't appreciate the rich, full flavor of Camels. See if your *own* throat doesn't welcome Camel's cool mildness.

Let your own experience tell you why, with scores who have tried, Camels are the "Choice of Experience."

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More Doctors Smoke CAMELS

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In a nationwide survey by three independent research organizations, 113,597 doctors were asked to name the cigarette they smoked. More doctors named Camel than any other brand.

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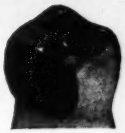

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No.900 *SOFT TYPE A—Coin gold color. For gingival and small occlusal inlays, subject to little stress.

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It is soft in the quenched state for clasp and bar adjustment and responds beautifully to heat treatment. It casts the way you like it and does not develop accidental brittleness during slow cooling.

**Extra hard gold for which no A. D. A. Specification has been set

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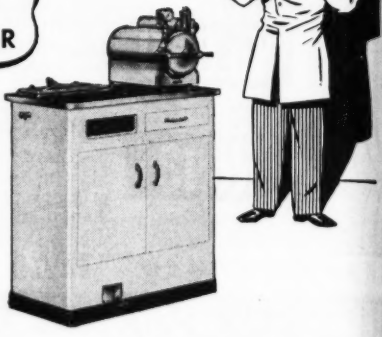

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Clear the gas and air lines of impurities by opening the valves wide before using the blow pipe.

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Let that distinctive, tangy Kolynos taste give those "brush-your-teeth" instructions an invaluable assist. Once a patient has discovered how Kolynos makes a session with the toothbrush a delightfully refreshing experience, conscientious tooth care is no longer an annoying, conveniently forgotten chore.

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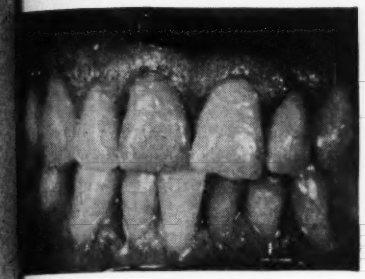

Chronic Vincent's infection of 5 years' duration. Despite continuous treatment during that period, there was persistence of bleeding gums, pain and malodor.

Following one month's treatment with Chloresium dental therapy—there was no swelling or bleeding, no pain, no odor. The tissue was normal. Patient dismissed.

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We invite you to try Chloresium Dental Ointment, Solution (Plain) and Tooth Paste on your most resistant case for any condition which calls for accelerated healing. Mail coupon below.

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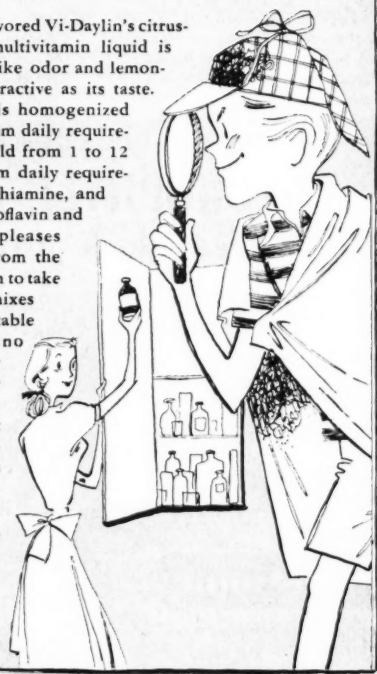
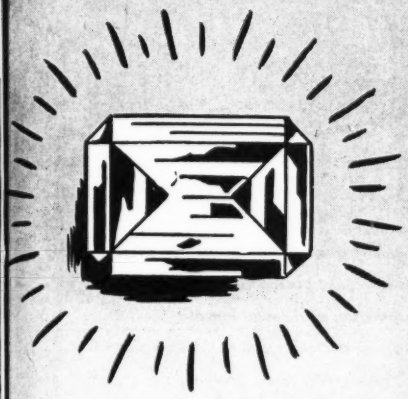


VI-DAYLIN

(VITAMINS A, D, B_1, B_2, C AND NICOTINAMIDE IN LIQUID FORM)



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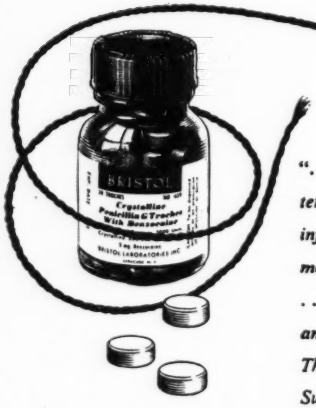

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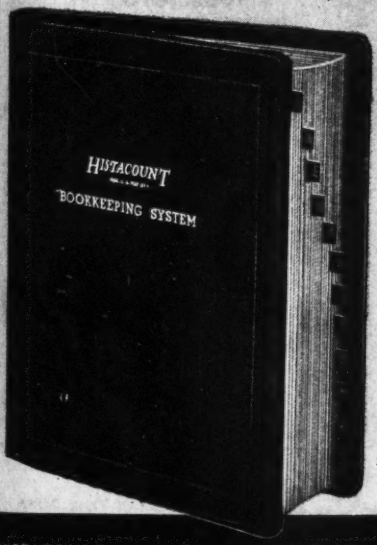

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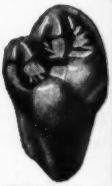

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Picture of the Month

A NEW TYPE of dental health recordings made by motion picture stars and radio entertainers under the direction of the Southern California State Dental Association are tried out at the American Dental Association Meeting in Chicago. Left to right: James Robinson, Los Angeles, Executive Secretary of the Southern California Association; R. Mott Erwin, Jr., Portland, Oregon, Past-President of the American Society of Dentistry for Children; and Alfred E. Seyler, Detroit, President of the same organization. (See page 1920.)—*Photograph by Howard A. Hartman, D.D.S.*

Ten dollars will be paid for the picture used in this department each month. Send gloss prints with return postage to ORAL HYGIENE, *708 Church Street, Evanston, Illinois.*

This practitioner's program of dental maintenance for his patients has resulted in a large and gratifying practice.

Preventive and Protective Dental Maintenance

By E. L. KIRSCHBAUM, D.D.S.

APPROXIMATELY seventy thousand dental practitioners in the United States are rendering adequate dental service to only about 20 to 25 per cent of our entire population of 140,000,000 people, yet all offices have long waiting lists of patients seeking dental service. What is wrong with our present approach to a complete dental health service?

Our present approach to dental health care places too much stress on the technical restoration of the mouth rather than on the preventive and protective phase after the mouth has been restored. Our fine teaching institutions, research men and clinicians throughout the country, and the millions of dollars that are being spent annually on giving the profession every means available to produce the finest dentistry in the world, are of great value. We all admire that beautiful gold inlay, amalgam restoration, or bridge, but do we have any plan to prevent the loss of that tooth or bridge, or any plan to protect that tooth?

While attending a dental meeting this spring, I listened to a clinic presented by a dentist who has done much for the profession. He is outstanding in the field of amalgam and inlay restorations. At the end of his clinic he showed the group an inlay restoration invested in a human tooth. This inlay had seen fifteen years of service in the mouth and was still in excellent condition. It was a work of art and a credit to the profes-

sion. Yet the tooth that should have been in the patient's mouth was mounted on a small pedestal to portray fine craftmanship that gave fifteen years of service. The distal was destroyed by dental caries which had entered the pulp chamber.

Who was at fault, I do not know; but if this dentist had a plan to protect that tooth he is not guilty. If he did and the patient ignored the plan of protection, the guilt rests with the patient and the dentist discharged his professional responsibility.

Dental Cripples

Dental caries is common to all; few persons are immune. The person who has never had dental caries up to 60 years of age can develop it, although this is unlikely. The onset of caries may be gradual and continue slowly over the years, or the disease may appear early and continue with great rapidity. In either case, the result to patients is loss of teeth and broken or impaired health. These persons are our dental cripples. Protect them and you prevent this.

It is these dental cripples whom we are trying to help in our dental offices. The mouth is restored and the patient discharged. In a few years he returns and we start all over again. Perhaps several more teeth are lost and another bridge or partial denture is inserted. The patient is upset because of more lost teeth and another large dental bill. A few more of these experiences and the patient is ready for dentures.

The time and effort spent on one bridge would take care of several patients requiring simple restorations. Prove to the patient that dental maintenance is cheap health insurance, but delayed or neglected dentistry is expensive.

We as members of the dental profession should discharge our responsibility to our patients by the proper approach to dental health. This approach can be accomplished only by correct and accurate diagnosis, restoration, and regular dental treatment; summed up in two words, commonsense dentistry.

Plan of Treatment

Let us start with the child 2½ to 13 years old, for here is our principal source of dental disease. It is known to the profession that in the 5-year age group 90 per cent have caries and have lost one tooth.

The first appointment with the patient consists of a routine prophylaxis, brushing instructions, and the presentation of a brushing kit. A clinical examination is given, exploring pits and fissures for caries; bitewing and other necessary roentgenograms are taken. A dental health talk is given in a few simple words to the mother; explaining the importance of diet, the place of sodium fluoride in reducing caries, and any malformations that might exist or need observation, if she has not had previous instruction. This first ap-

pointment is a fine introduction to dentistry for the small child. It is at this age, with parent cooperation, that we can prevent dental cripples and start a real preventive and protective health program for the child at a minimum cost.

This preliminary treatment can be given and explained by your dental hygienist if you are one of those fortunate practitioners who has a hygienist in your office. She can save the dentist much time that can well be spent on restoring teeth. I hope the time will be soon when the hygienist will be well known in the field of dental health, and we will have more of these rare persons so that every office may employ one.

The child is now given the appointment for his restoration program. This program is divided into two phases. First, the hard tissue program, which consists of restoring tooth structure, removing necessary teeth, inserting space maintainers if prescribed, and restoring the mouth to a healthy condition. The second phase in the child's program consists in the observation of manifestations of malconditions for orthodontics, or too long retention of primary teeth that may lead to malconditions.

We are now ready to guide the child to adulthood in dentistry. This is the most important point I wish to bring out. When the child has twenty-eight permanent teeth, not counting the third molars, he is dentally mature. If there is loss of teeth now, Nature will not replace them with a third set.

Let me mention another fact that is known to the dental profession. In the 15-year age group 48 per cent show the loss of one permanent tooth. Already at the age of 15 years we have 48 per cent of our children, or let us call them young adults, coming to our offices as dental cripples who will go the rest of their lives as such. To me this is a dental catastrophe, and it can be avoided.

Office Records

Now let us return to our child 2½ to 13 years of age whose preliminary treatment has been completed. He is classified in our office. If no permanent teeth have been lost, his file folder and recall card are in blue and segregated in the filing cabinet. In other words, the noncripples are separated from the cripples in the files so that we can give the attention required by each group.

The records for the dental cripple or any patient who has lost one or more permanent teeth are filed in the same manner with the folders and recall cards in red. We are just as interested in this patient and give him the same opportunity to have dental health maintenance to prevent further loss of teeth. This file or list of patients is a heavy potential for bridge or partial prosthesis.

These patients are now placed on our preventive program and recalled to the office at four- to six-month intervals as the need may

be. This is done through a monthly card index system, and each month the recall notices are prepared for mailing. We mail about one quarter each week and the patients telephone for their appointments.

This is an excellent patient control, and our appointment book is only scheduled one week in advance instead of one month or one year as in some offices.

Let us now consider the adult dental patient, the patient 13 or more years of age. This routine is much the same as for the child patient except that we have soft tissue problems with which to contend.

The first appointment is the same except that we may have a periodontal condition beginning and, therefore, we use instrumentation in giving the prophylaxis. We look for any tissue breakdown and protect against any soft or bony tissue disease because of calculus deposits, overhanging restorations, or traumatic occlusion. Here again the mouth is put into a clean, healthy condition before operative or restorative treatment is begun.

Recall System

This patient is also classified and given the opportunity to be placed on a recall system.

There are various methods of placing the patient on a recall system. We merely notify the patient by card that he may call the office for an appointment for his prophylaxis and examination. This gives me the interested patient. I tell the patient we are only interested in the patient who is seeking dental health. This builds a fine practice in which the patients return with clean, healthy mouths.

No program will be 100 per cent satisfactory, and we drop the patient who does not return rather than continue to mail notices. This keeps our files active.

If a patient drops and then returns of his own accord, he is treated as a new patient. If we cannot give him an immediate appointment, he is placed on the waiting list to be called when we can take him.

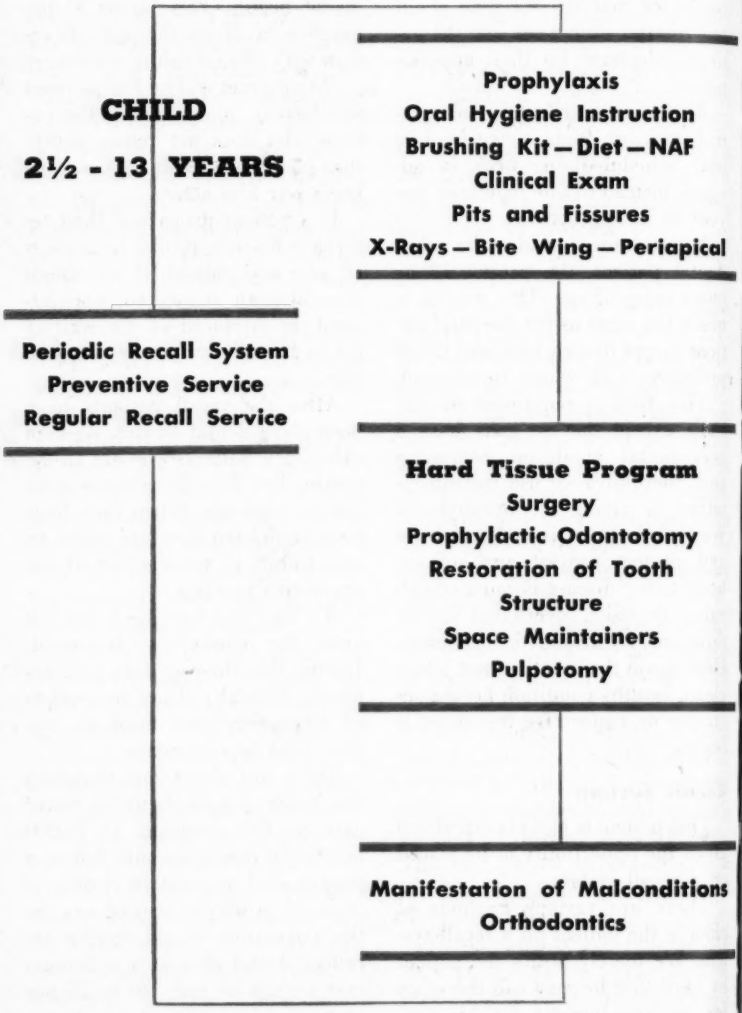
After the recall patients have been given dental service, we then call in new patients who are on the waiting list. We take as many as we can each month. When they have been completed they are given an opportunity to become part of our preventive practice.

We have one hour each day left open for emergency treatment. During this time we take patients having difficulty. They are rendered emergency care until we can give them appointments.

There are about one thousand one hundred patients under active care on this program. If 70,000 practicing dentists would follow a program of preventive dentistry, from 50 to 60 per cent of our entire population would receive excellent dental care at a minimum cost instead of only 20 to 25 per cent receiving adequate dentistry.

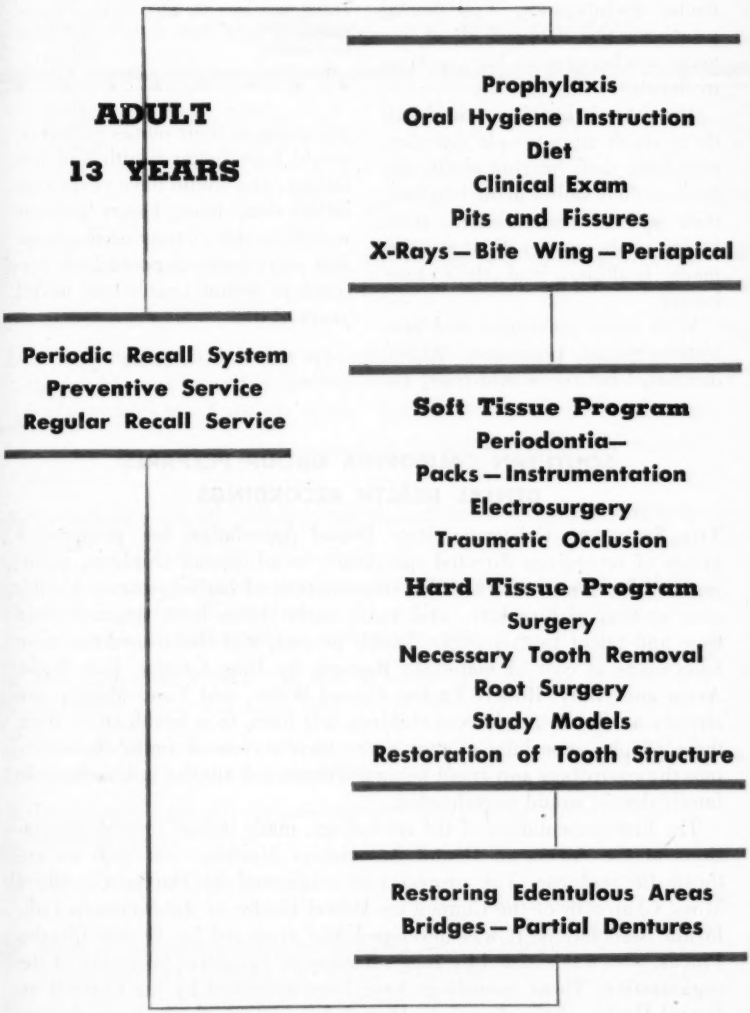
A program of this nature can be

A Program for Protective



1918

and Preventive Dentistry



1919

practiced in part or as a full-time practice. We devote our entire program to preventive dentistry and dental maintenance. Full dental prosthesis was dropped about five years ago because we have no time to devote to this service.

Dentistry is fighting a hard battle to reach more people that they may have their hearing ability defended, their smiles made brighter, their speech made clearer, their breath made sweeter, their systems made healthier, and their lives longer.

With more preventive and protective dental programs, 70,000 dentists, I believe, would really enjoy going to their offices each day, would have better health and less fatigue, and would have years added to their lives. Fewer patients would be the victims of dentures, and more patients could look forward to dental health and added years of life.

116 *East Superior Street*
Alma, Michigan

★ ★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by E. L. KIRSCHBAUM, *D.D.S., has won the* $100 ORAL HYGIENE *award for the best feature published this month.*

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SOUTHERN CALIFORNIA GROUP PREPARES DENTAL HEALTH RECORDINGS

THE SOUTHERN California State Dental Association has prepared a group of recordings directed specifically to adolescent children; pointing out the danger of excessive consumption of carbohydrates. Prominent motion picture stars and radio entertainers have donated their time and talent to this public health project, and the recordings have been made at cost of materials. Records by Bing Crosby, Bob Hope, Amos and Andy, Robert Taylor, Cornel Wilde, and Tony Martin, are already available. Adolescent children will listen to a health story from these people; especially as they carry their screen or radio characters into the recordings and avoid being ponderous. A similar talk from their family dentist would go unheeded.

The first presentation of the recordings, made before several associations at the American Dental Association Meeting, met with an enthusiastic response. The project was originated by Doctor C. Albert Moss, Chairman of the Council on Dental Health of the Southern California Association. It was developed and arranged by Doctor Charles Pincus, who was assisted by James Robinson, Executive Secretary of the organization. These recordings have been approved by the Council on Dental Health of the American Dental Association, through which they will soon be available to the profession.

So You Know Something About Dentistry!

QUIZ LI

1. (a) 90 per cent, (b) 64 per cent, (c) 31 per cent, of impacted cuspids are found on the lingual or palatal surface of the alveolar ridge. .....

2. In the maxilla, the labial and buccal plates absorb (a) much faster than, (b) approximately the same as, (c) much slower than, the lingual plates in edentulous areas. .....

3. Are silicate cements soluble, tending to disintegrate in the mouth fluids? .....

4. The *p*H of a freshly prepared solution of procaine hydrochloride is about (a) 4.2, (b) 5.5, (c) 7.2. .....

5. Amalgam may be removed from diamond points by (a) soaking points in warm saline solution, (b) putting points in mercury, (c) thoroughly scrubbing points with strong soap. .....

6. Including the mandible, the skull is made up of (a) 22, (b) 24, (c) 19 bones. .....

7. True or false? Bone serves as a calcium reservoir, but the enamel and dentine cannot be so regarded. .....

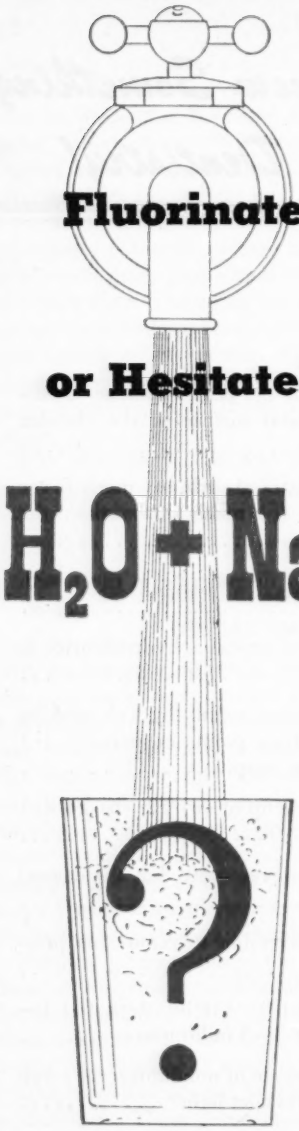
8. Do women have an apparent greater aversion to removable prosthesis than men? .....

9. The ideal gingival sulcus (crevice) is (a) 0—1 millimeters, (b) 1—2 millimeters, (c) 2—3 millimeters, (d) 3—5 millimeters. .....

10. What is the appearance of restorations made of nonfluorescent acrylic resins in (a) sunlight, (b) under ultraviolet light? .....

FOR CORRECT ANSWERS SEE PAGE 1952

Fluorinate or Hesitate?



By BURKE W. FOX, D.D.S.

IN A RECENT magazine article[1] F. A. Bull, D.D.S., M.P.H., urged the dental profession to recommend the addition of one part per million of fluorine to public water supplies. This is recommended despite the fact that he refers to *The Journal of the American Dental Association* as stating that "it has *not* been established" that this will definitely reduce dental caries. A careful search through the literature has revealed several similar recommendations, but not one claims that sodium fluoride added to water supplies is a *proved* agent in reducing caries.

There is certainly enough evidence in favor of this theory to justify a thorough testing, and I believe such adequately controlled experiments as those now under way at Newburgh, New York; Grand Rapids, Michigan; and Evanston, Illinois, should be encouraged. However, if we are scientists, should we not try all possible tests to prove or disprove this theory before endorsing it universally? Are there no questions needing to be answered?

The caries control committee of the Michigan Workshop, reported in the January, 1948, issue of *The Journal of the American Dental Association* that this statement made in 1942 remains true today: "There is no direct evidence

[1]Bull, F. A.: Should Fluorine Be Added to Public Water Supplies? DENTAL DIGEST 54:346 (August) 1948.

demonstrating whether or not the addition of fluorine to a fluorine-free community water supply will decrease the incidence of dental caries in the community."[2]

Fluoride Areas

Statistics gathered by the U. S. Public Health Service after examining approximately fourteen thousand school children in natural fluoride areas, when compared with other cities, indicated a lower rate of caries in the fluoride areas. Other investigators have not always been in agreement. Cheyne and Boyd, in the *Journal of Pediatrics*, reported: "There was no evidence that the current consumption of water containing submottling amounts of fluoride had lessened caries progress in children whose enamel was free from mottling."[3]

The Smiths of Arizona University, at St. David, Arkansas, (fluorine content, 1.6 to 4.0 p.p.m.) found the caries rate among children in line with that found by the U. S. Public Health Service, but found the teeth of adults in the area abnormally diseased. I should like to see figures on adult teeth in some of the areas with only 1 p.p.m. of fluorine in the water. The Smiths' report in the *American Journal of Public Health*[4] should be studied.

There are several references in the literature to increased periodontal disease in fluoride areas, but I have seen no accurate statistics. This increase may be slight, but I should like to know what amount it is.

Fluoride area statistics show only a slight reduction in caries of posterior teeth, but about 90 per cent reduction in upper anteriors. Does the beneficial effect of fluorides result from surface contact or ingestion? If from surface contact, then why should we swallow a substance which has even the slightest possibility of being toxic?

The reduction in caries among children in natural fluoride areas was figured by comparison with other cities which did not have fluorine in their water. However, recent investigations by Klein in New Jersey led him to state that some cities seem to have in their water a factor which accelerates decay.[5] If this should prove true, all cities with water containing this accelerator will have to be thrown out of the control list. When this is done, the comparison may not be nearly so favorable to the fluoride areas. In fact, if Klein's new theory is true, we may in a few years be

[2]The Michigan Workshop on the Evaluation of Dental Caries Control Technics, J.A.D.A. **36**:3 (January) 1948.
[3]Boyd, J. D., and Cheyne, Virgil: To What Extent Does Fluorine Ingestion Lessen Tooth Decay? J. of Pediatrics **29**:293 (September) 1946.
[4]Smith, M. C., and Smith, H. V.: Observations on Durability of Mottled Teeth, Am. J. Pub. Health **30**:1050 (September) 1940.
[5]Klein, Henry: Dental Effects of Accidentally Fluorinated Water: I. Dental Caries Experience in Deciduous and Permanent Teeth of School Age Children, J.A.D.A. **36**:450 (June) 1948.

urging cities to purchase equipment and supplies to eliminate this caries accelerating factor rather than urging them to add fluorine.

Fluorine Toxicity

Doctor Bull brushes aside the possibility of fluorine toxicity by stating that millions have drunk water containing fluorine for many years with no ill effects, and that there is no difference in natural fluorides and the artificial addition of sodium fluoride.

Certain experiments have been made to test the toxicity of fluorides, but these are not conclusive. McClure's check on fracture rate was made among young soldiers, the cream of young manhood, which might not be a picture of the entire population.[6] McClendon and Foster tested fluorapatite.[7] But this experiment was of doubtful value since fluorapatite is almost insoluble, even in acids, so is eliminated by the body without storage.

It is stated that there is no difference in natural fluorides and those added artificially. However, many of the statistics refer to water containing calcium fluoride, which is much less toxic than sodium fluoride, because it is less soluble.

Buffering Elements

There is also the question of buffering elements. We all know that acids can be neutralized with soda. Sodium fluoride can be "neutralized" by calcium carbonate or magnesium oxide. The water analysis of some of the natural fluoride areas shows that these buffering compounds are present in the water.

The buffering effect was shown in an experiment by Smith and Shaner.[8] Double the lethal dose was given to two laboratory animals with fatal results. This double dose was given to another two, but with the addition of an equal amount of calcium carbonate. These animals showed no ill effects. So the argument that millions have drunk water containing calcium fluoride or even sodium fluoride, if the water also contained these buffering elements, does not mean that sodium fluoride without these buffers is entirely safe. The experiment at Newburgh is giving special attention to the question of the toxicity of sodium fluoride in small amounts.

Many drugs, highly beneficial to most, are still dangerous for some few. Even the sulfa drugs and penicillin cause unfortunate reactions in some patients. We should be cautious about recommending the universal use of fluorine until we are *sure* it is safe for *everyone.*

Pasteur was severely criticized for not immediately giving the results of his experiments to the public, but he tested and retested for

[6]McClure, F. J.: Fluoride Domestic Waters and Systemic Effects: I. Relation to Bone-Fracture Experience, Height and Weight of High School Boys and Young Selectees of the Armed Forces of the United States, Public Health Rep. **59**:1543 (December 1) 1944.

[7]McClendon, J. F., and Foster, W. C.: The Non-Toxicity for Adults of Flourine in Tooth Powder, J. Dent. Research **25**:183 (June) 1946.

[8]Smith, R. R., and Shaner, E. O.: Effects of Buffered Lethal Doses of Flouride on Guinea Pigs, J.A.D.A. **31**:1483 (November) 1944.

years to be *sure*. Doctor Bull states that we risk only the expenditure of 10 cents per capita annually if fluorination is of no value. It seems to me that the dental profession also risks the loss of public confidence as to our scientific standing if we recommend something without waiting to study the experiments and their results.

Teeth have been decaying for thousands of years. Fluorination, if it is all we hope, may reduce caries to some extent. But it is not such an acute condition that we must leap before we look. And if fluorination should fail, will we be able to get public backing for any other project later with the public reputation of being optimists rather than scientists?

It might be well to recall the statement by Doctor David B. Ast, one of the planners of the Newburgh experiment, in the *New York Journal of Dentistry*: "Scientific skepticism is a healthy attitude and should be applied to all research and statistical data. This is especially true in regard to fluorine therapy, which may carry some individuals or groups away with more enthusiasm than scientific evidence may warrant.

"Therefore, let us read the reports as they come through critically, and let us be patient to await conclusive evidence before we make up our minds on the merits of fluorine therapy."[9]

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[9]Ast, D. B.: Progress Reports on Fluoride Investigations, N. Y. J. of Dent. 16:16 (January) 1946.

121 *West Seventh Street*
Charlotte, North Carolina

NEW JERSEY OFFERS NEW PLAN OF EXAMINATION

DENTISTS WHO have been graduated from recognized dental schools for ten years or more and licensed in other states now may elect to take a special examination for licensure in New Jersey instead of the regular clinical and written examinations. This special examination offered by the State Board of Registration and Examination in Dentistry consists of a more comprehensive clinical examination, and, in place of the written examinations, an oral examination in which the dental application of the basic sciences is stressed.

The four sections making up the special examination are: clinical prosthetic dentistry; clinical operative dentistry; clinical oral diagnosis and treatment planning; and the oral examination by a committee of examiners.

By JOAN THOMAS

THERE IS NO such thing as *free dentistry*. If the patient is not paying for his treatment, the dentist himself most certainly *is*.

As soon as a man receives a degree in dentistry, that is the signal for the gathering of the clans. His announcement of the opening of his new office is taken for an invitation for a family reunion. His sisters and his cousins, his aunts and his uncles, together with their accumulations by marriage, come rushing from near and far and converge on his doorstep for a "dental handout."

If this practice is not squelched in the beginning, it grows like the proverbial snowball, until the dentist is buried under its weight. Far too many "soft-hearted Johns," who were "good fellows" during their years of practice, spend their old age in penury for this reason.

Something must be done about it. But what? Few dentists are good business managers, but, however much they may dislike the

prospect, they must spend some time learning the basic principles of office management. It is quite as necessary for a dentist to be able to manage his business affairs as it is for him to be a good operator, if he is to survive in the modern world with any degree of security.

Overhead

In order that he may understand what he is giving these "dental panhandlers," an inventory should be made of office overhead. This should include rent, electricity, telephone, supply bills, assistant's salary, cleaning and laundry costs, and other expenses. *Nothing* should be omitted! By taking this total for the period of a month and dividing it by the number of hours actually spent at the chair in productive service, the cost per hour of maintaining the office may be ascertained.

When the dentist is tempted to do a restoration or other dental operation "for free," with the thought that the amalgam is hardly worth considering, let him remember instead that *the time it takes to do this service* is costing him actual hard-earned cash. This loss must be charged up to other patients, and this will result in a reputation for high fees with a consequent falling off in patients who pay their way. Every hour the office is open the overhead is going on, and the dentist's *time* at least must be paid for or his financial statement will show a loss.

Dentist's Relatives

Some of the relatives will offer to pay for their treatment. A man should start right out by accepting this payment. If these people are the right sort they will realize the dentist, particularly if he is just starting in practice, needs paying patients.

If the relations do not offer to pay, a statement should be sent to them. More than likely they will ignore it, but the dentist wins either way. People who take this attitude are obviously ones who do not make good patients—relatives or not—and should they be highly indignant and not come back, the practice is much better off without them.

One way to handle this situation is by making a scale of fees for general patients. The relatives should be divided into groups. If there are some whose presence is not desirable, double the fee! For the remainder, those outside the immediate family might be given a 20 per cent discount. Brothers and sisters rate a little better than this, and they might be given a "cut" of 50 per cent.

In many cases it is because of the efforts of the parents that a young dentist finds himself in practice, so they should be on the free list. Parents *invest* not only

time but money in their sons when they finance their college education—and they should realize something from that investment.

Where to draw the line is a major problem, and a perplexing one. In some cases the dentist may have a distant relative who has loaned money to assist him in starting practice, or for some other reason he may feel himself in debt to some relative. Such circumstances will alter the category in which this relative should be placed, and the dentist must decide for himself what allowances to make. However, for those whose only claim to consideration is the timeworn cliché that "blood is thicker than water," it should be pointed out that neither blood nor water will pay the rent.

Physicians

There is also the question of professional courtesy to physicians. Many dentists make a practice of placing *all* physicians on the free list, and there again they are running into difficulties. A 20 per cent discount is a much more reasonable arrangement, with the dentist's personal physician rating the free list.

If the medical and dental professions were more nearly equal in number of registrations, this would not be so necessary. But such is not the case. Even if it were, there is no guarantee that each physician will choose a different dentist. Often in large buildings given over to professional offices half a dozen or more medical practitioners call on one man for their dental services. The same is true of dentists making use of the services of medical practitioners, though, because of the lower registrations of dentists, this is not such a hardship for the physicians.

According to Doctor R. W. Bunting, Dean of the School of Dentistry, University of Michigan, in 1947 there were 3,409 dentists registered in his State, while at the same time there were 4,536 physicians.

Across the border, in the Province of Ontario, the figures are much more discouraging from the dentist's point of view. Doctor Don W. Gullett, Registrar-Secretary of the Royal College of Dental Surgeons, reports that there are approximately two thousand dentists registered, while there are (also approximately) five thousand three hundred medical practitioners.

The same conditions are general in other states. As a result, the dentists, who supply not only advice but in many cases actual service and materials without fee, are coming out on the small end.

It could happen that existing conditions might lead to strained relations between the two professions. The dentist might well ask himself: "Why should I do this man's treatment without charging? He's never done anything for me. But 'professional courtesy' says I must."

On the other hand, thoughts of a

similar nature might annoy the physician. "I can't charge this man," he might say to himself after a midnight obstetrical case. "He did a prophylaxis for me last week and wouldn't accept a fee."

Because of the misunderstandings which are likely to arise, it would be more satisfactory if the medical and dental professions came to an agreement on this question of "professional courtesy." If the whole matter were put on a business basis, there would be much more courtesy involved than with the present hit-and-miss method.

Conditions differ in small towns, but in some the two professions work together as a team. When this is the case "let your conscience be your guide" holds good, but in cities, with high overhead on both sides, there should be a business understanding.

The same might be said for the clergy. Few of these men receive high salaries, and some consideration may be given them. However, the dentist is not being fair to himself if he gives away his services to every member of a religious order who comes to him. The clergy do not expect it. Courtesy should be extended to them, but the dentist must be able to distinguish between courtesy and a lavish handout.

Those who have been in practice over a period of years already have a long and imposing "free list." These men will find it difficult to break away from the old habit of not charging for their services. However, there is no better time than the present to change these conditions. The rising cost of living, higher office maintenance, cost of supplies and new equipment, are excellent reasons to give these patients for commencing to charge them for services which were formerly given away. Here again, the desirable ones will understand the situation and be glad to cooperate. The others will fade away, but their loss is the dentist's gain.

Reductions

These remarks must not be taken to apply to those who are *unable* to pay the regular fee. Every dentist will have patients periodically who, through some misfortune such as illness or loss of employment, will be financially unable to assume any extra expenses. Here is where *real* courtesy comes in. If the case is genuine, only the dentist's conscience should guide him.

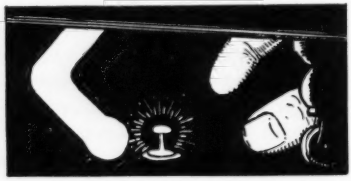
However, no reduction should ever be made without first telling the patient. If such is done, he is likely to assume that is the regular charge. Others may hear of it from him and be misled into thinking you are overcharging them when the regular fee is quoted.

No patient who is suffering should ever be turned away without receiving treatment. However, when it becomes necessary to supply emergency treatment gratis, it is a good plan to inform the patient that this is being done, and

(*Continued on page* 1954)

Dentists in the News

Mechanix Illustrated: After twenty years of practicing oral surgery, Doctor David L. Weiss retired to devote his entire time to his hobbies. Because of these hobbies, thousands of man-hours were saved during the war. This dentist is considered one of the top creators of precision instruments in the country.



During the years he practiced dentistry, Doctor Weiss devoted his spare time to tinkering with gadgets and knick-knacks. When lucite came on the market, he thought of making surgical instruments out of it—instruments that would carry their own cold light into the areas being treated. Soon he was busier making such instruments for physicians, gynecologists, and otologists than he was treating patients.

When not practicing dentistry or inventing, Doctor Weiss spent his time on other hobbies. His interests carried him into the fields of hypnotism, painting, playing the piano, and flying seaplanes.

Chicago (Illinois) Daily News: Doctor Clark J. Cameron, a practicing dentist in Cherry Tree, Pennsylvania, at the age of 92 is still able to keep most of his appointments. He estimates that he has made 10,000 dentures during his years of practice.

Nashville (Tennessee) Banner: Doctor Oren A. Oliver, Nashville dentist and wartime President of the American Dental Association, was awarded the Selective Service Medal and a Congressional citation signed by President Truman. The presentation was made by President Truman's assistant military aide, Colonel Louis Renfrow, President-Elect of the International College of Dentists, at the annual dinner of the College which was held during the 89th Annual Meeting of the American Dental Association in Chicago.

The award was made because of Doctor Oliver's services performed in connection with Selective Service during World War II.

Philadelphia (Pennsylvania) Bulletin: Dentist-explorer Harry Wright has returned from a South American trip on which he and his friends visited an Indian tribe in Brazil. The tribe was discovered a year ago by an expedition with which Doctor Wright was traveling. Pictures taken by the dentist appeared in *Life* magazine.

Doctor Wright also brought back a film of a 14-foot alligator being devoured in two minutes by thousands of Piranha fish.

Boston (Massachusetts) Post: Among more than three hundred men in the New England area, Doctor Donald F. Gerhart, a dentist who is a staff member

at Cushing General Hospital, a Veterans Administration hospital in Framingham, Massachusetts, is already famous. These men are Army and Navy veterans of both World Wars who suffered battle or home-front injuries that resulted in the loss of one eye. They know Doctor Gerhart as an expert in the manufacture of artificial eyes.

Every veteran who goes to Cushing General Hospital for a new eye gets one that is custom built. The eyes are made of a plastic which weighs less than glass, is unbreakable, and permits a perfect match. The patients stay at Cushing while the eyes are made. This usually takes three days.

"No two people have eyes alike," says Doctor Gerhart. "A man's eyes are as individual as his fingerprints. Each man requires a different treatment, the way each sitter requires a different portrait."

Doctor Gerhart is assisted by Willard H. Rice, a dental technician, who does the painting and the precise matching of colors and flecks.

Nearly all the eyes made at Cushing Hospital are left eyes. Even men who were hit in battle and from the right lost their left eye. This coincidence prevails in three quarters of the patients, and Doctor Gerhart cannot explain why this is true. Three eyes are made for each patient: one for day, one for night with a dilated pupil, and one to keep on file at the hospital so that the eye can be duplicated by mail if necessary.

Doctor Gerhart finds his specialty of making and fitting artificial eyes gratifying. His last patient, when trying on and examining his new eye, grinned and said: "I can see better already."

New York (New York) World-Telegram: Doctor William T. Osmanski closed his Chicago dental office for four months to coach the Holy Cross football team this year. He had one man from the staff of former coach Ox DaGrosa—Ed Kosky, giant end coach. With a squad of thirty-two lettermen who played unpredictable football in 1947, Doctor Osmanski set out to prove that a veteran squad schooled in single wing can be turned into a T club in a year's time.

Philadelphia (Pennsylvania) Enquirer: "Take it out, Doc," requested Doctor Herbert Fleisher's patient as he sat in the dental chair displaying a costly permanent bridge with considerable gold.

The Philadelphia dentist could find nothing wrong with the bridge and told the patient so. "Well, if you want to know the truth," the patient replied, "I want that bridge out so I can sell the gold. I'm broke and hungry and I need the money."

Doctor Fleisher explained that that was not ethical and gave him $5 to "tide him over."

Later, at a dental meeting, this dentist was telling his colleagues about this incident when four other dentists stood up. They too had refused to remove the perfect bridge and had given the hungry patient money to "tide him over."

Awards this month for items published in DENTISTS IN THE NEWS have been sent to the following:

DAVID DANETZ, D.D.S., 2207 North 15th Street, Philadelphia 22.
MRS. ROBERT NOLAND, JR., 3507 Nolensville Road, Nashville 11, Tennessee.
MRS. E. L. CORMIER, 41 Kimball Extension, Sanford, Maine.
RICHARD A. KIMAN, D.D.S., 178 East 70th Street, New York 21.
LOUIS L. BINDER, D.D.S., 5237 North 5th Street, Philadelphia 20.
FRANK VOLINSKY, 1411 Stebbins, Bronx, New York.

Don't Pay Twice for New Buildings

By HAROLD J. ASHE

DENTISTS NOW building or about to build offices, income properties, or private homes should be on notice that, if they do not exercise diligence and foresight, such structures may cost far in excess of the contract price. This warning applies also to additions, alterations, and even maintenance repairs.

Usually when major construction is involved the dentist will employ a general contractor. Periodically, payments will be made as the job progresses, and the dentist may conclude erroneously that there his responsibility ends. With the final payment he may assume that the building is clear of encumbrances; except for such financing as he has previously arranged. If, however, at some point in the progress of these payments from general contractor to subcontractors, to material supply houses, and to the mechanics employed on the job, there has been a failure to satisfy the claims of any of those contributing to the construction, the dentist may find himself confronted with from one to a score or more liens on the building.

Lien Law

The majority of states now have some form of lien law designed to protect material supply houses, contractors, and mechanics. These laws stand unique in contractual relations. Historically, they have been placed upon the statute books to correct a widespread abuse by which material supply houses, me-

chanics, and, sometimes, subcontractors were left unpaid, and without recourse, when either general or subcontractors received payment but failed, in turn, to settle outstanding bills incurred in performance of the contract. Now, in fact, the mechanics, supply houses, and subcontractors can legally turn to the building owner for satisfaction of their claims, if otherwise not satisfied; even though they may have no direct contract or agreement with him. The fact that the owner paid the general contractors does not remove the builder's liability to subcontractors and material supply houses and mechanics.

Building owners, therefore, should not conclude that their responsibility ends with the payment of sums called for in the contract with the general contractor. And, even though the general contractor may be able to present tangible evidence that he has paid his subcontractors, this is still no assurance that material supply houses and mechanics of these subcontractors have been paid. At any point along the line from the general contractors to the employees of subcontractors and supply houses, there may be a stoppage of payment; giving rise to a lien against the building.

The building owner generally should scrutinize most carefully the competitive bids. The lowest bid well may suggest dangers ahead if it appears to be too low to permit performance of a first-class job. It may also indicate a financially irresponsible general contractor who does not know his true costs, and who may be tempted to indulge in sharp practices to protect himself against a loss.

Licensing Laws

It is usually not within the province of the builder to investigate the subcontractors used by the general contractor. However, if there are local or state contractors licensing laws, it will afford some small measure of protection to insist that only licensed subcontractors be employed. Legal shoals may be ahead for the builder if such subcontractors do not carry workmen's compensation or accident insurance.

Ensuring that the general contractors and subcontractors are licensed and insured, however, is not enough. Some of the most flagrant cases involving liens on buildings concern licensed contractors. If taking a loss on a job, they frequently have been known to pack up and leave town; failing to pay material bills or such wages as they can evade. About all most licensing authorities can do is rescind licenses; a penalty such contractors are reconciled to when they jump the job. The granting of licenses in the first place is usu-

ally less on the basis of personal integrity and known financial responsibility than upon mechanical skill of licensees. Court cases seldom recover misused funds from such contractors because, even when apprehended, they rarely have any resources. If they had they would probably have stayed and honored their just obligations.

Probably in no other field is it possible to engage in such large operations with so little capital as in the building trades. In fact, the lein laws actually encourage this condition by ensuring payment of material bills and wage payrolls by building owners. Supply houses readily lay down materials on job sites with little serious consideration of the credit status of contractors; knowing materials are protected by progress of the building.

The foregoing picture is not intended as an indictment of the building trades, or the many honorable men in it, but merely an attempt to focus attention on that small minority of unethical contractors. Ethical contractors are the first to condemn the jacklegs, the jerry-builders, the fly-by-nights in their ranks.

Releases

Builders, however, where lien laws exist, have a sure means of protecting themselves against liens. This protection is afforded them if they insist at the time the contract is executed that progress payments and completion payment will be made only following presentation of material and labor releases. These releases should state that material bills have been paid or waived, and that mechanics' claims have been satisfied, to date. These releases should originate through the subcontractors and come to the building owner from the general contractor.

Material releases should indicate, preferably, the quantities and kinds of materials laid down on the job, and when, and indicate that suppliers have been paid for such materials or that they waive any claim for payment against the named job. These releases should be on supply-house stationery and be signed by a responsible firm member.

Labor releases should state that the mechanic signing waives wage claims to date of signing, or that he has received wage payment in full to date.

Releases signed by subcontractors, themselves, and sometimes offered in lieu of material and labor releases, are of no value whatsoever except to show that the subcontractors have received payments. They should be obtained, but they are no protection against liens for materials or labor.

It should again be emphasized that, in those states having such lien laws, the lien rides with the property until it is satisfied. The fact that somewhere along the line a general contractor or subcontractor has failed to meet his obligations arising from the job is no

defense legally for the building owner. This is true even though a contractor's failure to pay claims may give rise to a separate civil or criminal suit against him.

Maintenance Contractors

What has here been said of jobs performed through general contractors applies with equal force even to maintenance types of work performed through a specialized contractor, such as a painting job, installation of new glass, or repair of a heating system. Any improvement or repair made by building tradesmen to an already built structure may result in a lien against the building, if any claimant has been unpaid.

It may prove to be a profitable employment of time for the owner or someone representing his interest to note carefully the materials laid down on the job, the number of workmen engaged day by day by each subcontractor, and to evaluate these data in checking the material and labor releases tendered. Occasionally a subcontractor may receive materials for a job from two or more supply houses but furnish a release from only one. Or he may turn in labor releases from only part of his job crew.

Perhaps an owner may feel so sure of the integrity of a contractor, he may hesitate to take the safeguards outlined. Even though this integrity exists, there is always the possibility of sudden death of the contractor while the job is in progress. If progress payments have been made and no releases have been supplied, it may develop that the material supply houses have received no payment whatsoever from the contractor. They, too, may think highly of the contractor's honesty and be lax in their collections. However, this fact will not deter them from placing a lien on the job if, with the contractor's death and his terminated earning power, it develops his estate is insufficient to satisfy his indebtedness.

When the typical dentist builds, his investment may represent a major part of his life's savings from his practice. If ever he should proceed with caution, this is the time. With so much at stake he may well adopt that old adage: "Better safe than sorry."

2002 *Knopf Street*
Compton, California

CAN YOU USE A DOLLAR?

To EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News* (see page 1930), we will send promptly a crisp, new one dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

Dear Oral Hygiene

Socialized Dentistry

Dentistry, under a socialized health program, may begin with patients having the choice of any dentist on an approved list, but it is certain to wind up with the dentist operating in a Pentagonian health center under regulations not too different from those of Civil Service.

The temptation to criticize that with which one is unfamiliar is always great. But one need only visit a city hall or a local post office to see what Civil Service in dentistry may mean. Recent experiences with the dental branch of the armed services and with the Veterans Administration also suggest what may be expected.

In the lower ranks, the dentist will have little for which to hope. Positions will be assured by methodical adherence to the minimum standards. A record of attendance—clock-punching—and obedience to regulations will be of greatest importance. Without incentive, ambition will be thwarted. Individual initiative will be stifled. The dentist will gain advancement only by seniority; his path to promotion cleared only by death, retirement, or resignation. Ability and performance will not hasten his progress; below-average performance will not retard it. Compensation will be present only in the allaying of some fears and in the acquisition of a sense of some security.

In the upper ranks positions will be appointive. This means that service to the party in power will be a chief qualification. Ambition at this level will be satisfied only by competing for the favor of a superior officer or of some party mogul.

Buck-passing, the fear of assuming the authority belonging to a superior, the fear of making a wrong decision, and the fear of violating some regulation, can result only in delay and inaction. As responsibility for decisive action is passed along, the dentist will find himself enmeshed in the hopeless atmosphere of red tape.

Departments will be poorly administered and poorly coordinated. Overlapping of some functions and lack of provision for others will bring confusion and discord. Department heads will wrangle and compete for increased appropriations. At the same time, important functions will be cubbyholed because of lack of appropriations. Vested interests and various pressure groups will constantly demand consideration and thereby retard and interfere with efforts at efficiency in operation and function. Instead of a vital and progressive profession, allied to that of medicine, dentistry will be relegated to a position of mediocrity, secondary and dependent upon medicine.

Dentistry will suffer! The dentist will become warped! The public will be cheated!—M. R. Stern, D.D.S., 2945 *Avenue T, Brooklyn, New York.*

Service Dentistry

I am concerned over the item Government Dentistry by John E.

Waters, D.D.S., published in ORAL HYGIENE.[1] Operative dentistry in the Service usually was performed by men who are now in private practice; men upon whose judgment diagnosis and treatment planning rested. Those men were honorable, ethical dental surgeons. They were men of professional standing, licensed to practice in their respective states; including California. Some were men whose names are seen in the journals of dentistry; others were and are now instructors in dental schools. The integrity of these men must not be violated. If errors in diagnosis and treatment were imposed upon "innocent victims," it was the fault of these men.

I have seen excellent treatment in private practice "panned" by the lay "expert" who knows little or nothing of dentistry.

Must dentists continue to be their worst enemies? Can we not cease destroying ourselves? Don't we fare well enough without criticizing a fellow professional? Have you never made an error?

I do *not* defend socialized dentistry or medicine. I have been accused of conservatism and a reactionary trend. Samuel Johnson once said: "God, Himself, sir, does not propose to judge man until the end of his days." Why should you and I?—ALVIN H. CLAUS, D.D.S., 8505 *Fernald Avenue, Morton Grove, Illinois.*

[1]Dear ORAL HYGIENE: Government Dentistry, ORAL HYGIENE 38:413 (March) 1948.

AUTONOMY FOR DENTAL OFFICERS

REVISION OF Army Regulations to give autonomy to Dental Corps officers in a major command, army, division, or other headquarters has been reported.

The action, long sought by Army Dental Corps officers and by the American Dental Association, creates the staff title of "Dental Surgeon" and places the senior Dental Corps officers of above-mentioned units under direct responsibility of the commanding general for all professional, technical, and administrative matters pertaining to dental health. Heretofore, the Dental Corps officers have been responsible to the Chief Surgeon in the chain of command. In his new autonomous status, the Dental Surgeon will have direct control of enlisted personnel and will be responsible alone for efficiency reports on dental officers. Recommendations for promotion also will be made by the Dental Surgeon directly to the Commanding General.

In the Office of the Surgeon General, the Chief, Dental Division, will continue to be under supervision of the Surgeon General. However, in the field, the Dental Surgeon will occupy a similar staff status with the Chief Surgeon.—*The Army and Navy Journal.*

Editorial Comment

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

PREVENTIVE CARE IS WORTH MONEY

NO ONE HAS ever found an argument against the philosophy of disease prevention. Everyone has agreed that prevention is something to be sought earnestly. Most people, including dentists and physicians, accept the ideal of prevention but do little to motivate the ideal. We know but we do not act. We all violate the laws of hygiene and of good living; we neglect ourselves; we forego needed attention. Even so dentists have done more than any other group to spread the idea of periodic examinations and to emphasize the desirability of the early recognition and treatment of disease.

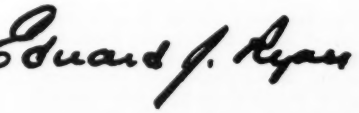
Most dentists use some kind of periodic recall system. Some use a method that is effective and dependable. A great many of us are hit and miss in our plan. Although we agree that our preventive efforts should be directed toward the child, many of us operate our recall systems with more attention being given to the adult. We give lip service to the importance of dental care for the child but most of our time is spent in caring for adults. The profit motive plays a part. Dental treatment for the adult is generally more remunerative. Until we place preventive programs for the child on a realistic and profitable basis they are likely to be neglected.

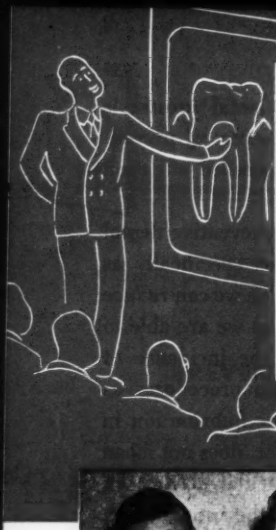
The prize-winning article in this issue by Doctor E. L. Kirschbaum describes how a dentist in a small community is able to give adequate dental care to children on a practical and profitable basis. Doctor Kirschbaum has gone so far as to operate his practice entirely for prevention. That is more than most dentists are prepared or are willing to do. In fact, it would be impractical for the majority of dentists because

there is an enormous unmet need and demand for dental prosthesis among adults. We must learn to fit the idealistic philosophy of prevention for the child into a practical system of supplying needed attention for adults. We cannot afford to neglect either group.

Speaking in strict accuracy, we cannot talk about a preventive dental program in the sense that caries can be controlled as specifically as typhoid or yellow fever. At our present level of knowledge we can *reduce* caries but cannot prevent it completely. In a large group we are able to make convincing quotations of figures to show that the incidence of dental disease for the group may be reduced by such procedures as reduction in the carbohydrate intake and the use of the fluorine ion in the water supply or by topical application. That, however, does not mean that we can be assured that the caries rate in any particular person can be reduced at the same ratio as it is among members of the entire group. For example, the incidence of dental caries in a large group of children may be reduced by 40 per cent by applying four topical treatments of a 2 per cent solution of sodium fluoride. The large group includes children who are immune to caries, those with a low index of susceptibility, and those who are highly susceptible. This does not mean, therefore, that in the highly susceptible individual child the rate will be reduced 40 per cent. We are liable to fall into serious error if we confuse disease incidence and control in a particular person with disease incidence and control in a large group.

A preventive program for children includes food prohibitions, the use of chemicals and drugs, oral hygiene, frequent examinations, and early correction of dental disease. Such a program is in large part an educational one as well as an operative one. Not until dentists are as well paid for their preventive advice and instruction as they are for their operative service may we expect effective preventive programs. The fault is not altogether with the public, but largely with ourselves.



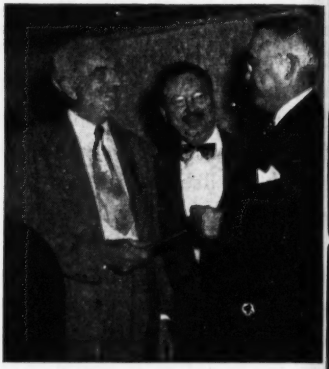


Portraits and Profiles

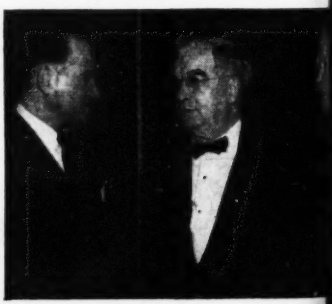
OF AMERICAN DENTISTS

By HOWARD A. HARTMAN, D.D.S.

Above: At the annual Clinic Day of the Toledo, Ohio, Dental Society are Clarence S. Musgrave, President-Elect of the Society; and C. A. Leslie, Chairman of the Clinic Day Committee.



Right above: At the Eighty-Ninth Annual Meeting of the American Dental Association in Chicago are (left to right): H. B. Washburn, St. Paul, Minnesota, outgoing President; Percy T. Phillips, New York, new Speaker of the House of Delegates; and Clyde E. Minges, Rocky Mountain, North Carolina, newly installed President.



Right: Samuel Fastlicht, Mexico City; General Leigh C. Fairbank, Washington, D. C.; and Homer B. Robinson, Hutchinson, Kansas, attend the meeting of the American Association of Orthodontists at Columbus, Ohio.

Above: Wendell D. Postle, Columbus, is installed as President of the Ohio State Dental Society at the annual meeting. Left to right: Roy C. Harkrader, Cincinnati, Vice-President; Walter S. Sargeant, Toledo, President-Elect; Doctor Postle; Carlos H. Schott, Cincinnati; and Earl G. Jones, Columbus, Treasurer.

Right (left to right): Germán Salazar, Medellín, Colombia; Godfrey Schroeder, Evanston, Illinois; and Paul Chung, Korea, at the Chicago meeting of the American Dental Association.

Right: At the Connecticut State Dental Meeting in Hartford are (left to right): Robert P. B. Hughes, Hartford; Ralph S. Voorhees, Jr., Rochester, New York, Essayist on Radiology; Charles F. Morgan, Ph.D., Georgetown University School of Medicine, Washington, D. C., Essayist on Antibiotics; and Charles E. Barrett, Jr., West Hartford.

Ask Oral Hygiene

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Sodium Fluoride

Q.—I shall appreciate your advice in this case. The patient is my 6-year-old granddaughter. Her first molars are in place and the lower central incisors. No other permanent teeth have erupted. The occlusal surfaces of the molars are extremely defective in the formation of the enamel. They are deeply concave, almost like cavities; and, of course, they are sensitive.

The lower centrals are notched and light brown in color. They are also defective.

The youngster is in normal health. Her brother, 10 years old, has good teeth; in fact, better than the average child.

Please advise me if you have found anything helpful in cases like this.—P. L. H., Illinois.

A.—There are two questions in the case of your granddaughter. The first one relates to the presence in the bone of the teeth which have not erupted. This question can be answered by roentgenograms.

The other question is what should be done to prevent the erupted teeth from decaying. Fortunately newly erupted teeth are most favorably affected by the topical application of sodium fluoride. So it would be wise to start using this at once and continue its use until the child is at least in her late teens.—GEORGE R. WARNER.

Fixed Bridge

Q.—I have just constructed a bridge with a three-quarter crown on the right lateral, which is a sound tooth, and a MOD inlay on the second bicuspid. This bridge supplies the right cuspid and first bicuspid and is fixed on the lateral and semifixed on the MOD inlay which also is sound.

It is a Veterans Administration case, and the Administration has found it unsatisfactory because the lateral carries too much of a load. They want me to remove it and make it an all-fixed bridge, a procedure with which I disagree. Therefore, I am writing for your opinion. Thank you kindly for your advice.—H. J. H., New York.

A.—In my opinion, both the way you have made this bridge and the way the Veterans Administration wants you to make it are wrong. A removable appliance properly designed would have been better. But between what you have made and what they want you to do, I would say that the patient is more likely to have satisfactory service from your bridge with a broken joint than he would if you remove it and replace it as a fixed bridge. The anterior and the posterior teeth have different types of or directional individual motion, so for this reason, and also because in such a bridge the pontics are set on a curve instead of a straight line, the strain on the

abutments is too great for a fixed bridge.—V. CLYDE SMEDLEY.

Systemic Condition

Q.—Under separate cover I am mailing you two teeth about which I should like some information.

The history of the case is as follows: The patient has been under my care for several years during which time he had little active caries. About six months ago I rebuilt his mouth extensively with inlays and several bridges.

Everything appeared to go along well until about three weeks ago when he came in for his periodic visit. I noticed that all his restorations were completely surrounded with some form of decalcification. Even a matter of days made a difference as to the condition of his teeth, so rapidly was this change taking place. The gold inlay attachments were all right a few months ago, and you will note from the specimens I am sending what has happened.

It was about this time that our patient began to take testosterone under a physician's orders. Have you had any reports of a similiar condition existing when this medication was being given? Or do you have any suggestions as to what might be causing this rapid decalcification? I believe it is now impossible to save his teeth.

I shall appreciate hearing from you regarding this case.—A. J. P., Wisconsin.

A.—Thank you for submitting to us this most unusual and interesting case, though it obviously involves a serious systemic condition outside the dental field.

One of the teeth you sent us contains a gold inlay of which any dentist would be proud. It is certainly a shame to see such beautiful restorative service as this lost from a mysterious, baffling cause.

I showed your letter and the extracted teeth to several urologists. They were all greatly interested but baffled and most anxious to learn more about the case. They would like to know what dosage of testosterone this man has been taking, for what purpose, and for how long. They also suggest clavical and long bone roentgenograms, thyroid and parathyroid tests, and a blood serum examination for calcium and phosphorus. Doctor Warner and I should greatly appreciate seeing full-mouth roentgenograms of this case, if possible, before your restorative treatment was started, and now. A complete record of what he eats and drinks as indicated on the enclosed chart might be helpful.

Doctor Warner is on the staff at Fitzsimons Hospital. He took your letter and the two teeth to Fitzsimons. The men there were much interested in your case but could not, nor can Doctor Warner, feel that there is any connection between the testosterone medication and the peculiar destruction of the teeth. They suggested that Doctor Warner roentgenograph the teeth; this he did and enclosed are the roentgenograms for your files. While these are interesting, they are not particularly, if at all, enlightening.

The destruction in these teeth is not from an acid, because the enamel does not appear to be affected. The destruction is much of the same character as we note in internal resorption of the teeth, and the cause of this is not established.—V. CLYDE SMEDLEY.

Thermal Shock

Q.—I have a patient, a man in his fifties, wearing a full upper denture. A few months ago I removed all lower

teeth except six anteriors and one second bicuspid. These teeth are in perfect condition. There is no gingival recession. I persuaded the patient to keep the teeth despite mild protest that they were sensitive to cold water. I have since placed a partial lingual bar denture.

The patient insists that thermal changes cause him difficulty. I have painted the tooth surfaces with formaldehyde solution with little apparent improvement. Is there any local treatment for this condition?—A. A. H., South Dakota.

A.—Ordinarily, sensitiveness to thermal shock in teeth results from one or more of the following conditions: caries, large restorations, occlusal wear which exposes the dentine, recession of the gingivae exposing the cervical areas, and traumatic occlusion.

If dentine is exposed, treatment with 33⅓ per cent sodium fluoride will usually relieve the sensitiveness.

Treatment for the other causes of sensitiveness is according to the cause.—GEORGE R. WARNER.

Mental Foramina

Q.—Several months ago I extracted the lower teeth and made a full lower acrylic denture for a man about seventy years of age who has worn a full upper denture for many years. The patient claims the lower denture causes a paralysis of the jaw on both the right and left buccal sides when he wears the denture, and that it is so annoying that he must remove it and let the jaw rest. I have trimmed the margins of the denture so I am sure there is no pressure on the mental foramen.

If you can tell me what you think is the cause of this condition, and what to do to correct it, I shall be grateful.—E. O. W., Minnesota.

A.—Can you locate the mental foramina with a finger tip? If so, I would suggest that you relieve the denture generously over this area one-fourth to one-half inch in diameter. The symptom sounds to me like pressure on the mental nerve. I am assuming that your patient means a numb feeling and not a motor paralysis.—V. CLYDE SMEDLEY.

Partial Denture

Q.—I have a patient about sixty years old who is wearing a palatal bar partial denture supplying the four posteriors on either side on acrylic saddles and rests and clasps on the cuspids. The posterior teeth meet and occlude with the lower teeth, but the anterior teeth are wearing down in both the maxillary and mandibular jaws.

By resetting the posteriors to open the bite enough so that the anteriors do not touch, will the wearing away of the anteriors be eliminated? Or will they have to have crowns or jackets on them so that they occlude? What is the average length of time it would take for the anteriors to elongate to meet again and begin to wear again, especially with acrylic teeth (this partial has porcelain teeth)?—M. J. C., Texas.

A.—In such a case we feel that the posterior saddles should be rebased or remade often enough to keep the anteriors in balancing function; contacting only when the mandible is protruded to the incisive relation. Even in this position the posterior teeth should take most of the stress. Acrylic teeth, of course, wear much faster than porcelain, and as you well know some ridges stand up much better than others. I would say, however, that in such a mouth the saddles should be reoccluded about once a year.—V. CLYDE SMEDLEY.

Devitalized Pulp

Q.—I have a patient, a girl 12 years old, who fell and struck her right central. It immediately turned quite

dark. There is some soreness but it is not acute. What treatment do you suggest?

I have had cases of teeth that turned dark after being struck and have stayed that way for years with no harmful results except for the appearance, but this patient is not pleased with the discoloration.—P. S. S., Colorado.

A.—It is possible for a traumatically devitalized pulp to be and remain infection-free for many years. However, it would be wise in the case of this patient to roentgenograph this tooth to be sure there is no periapical evidence of infection. If there is none, you can give the parents the choice of leaving the tooth as it is, but warning them that the pulp may become infected at any time; or having you remove the contents of the pulp canal under aseptic precautions, fill the canal, and then bleach the crown. If the bleaching process is not successful, a jacket crown will restore the esthetics.

I would be inclined, if the root apex is fully formed, to fill the canal now, and thus avoid a possible periapical infection.—GEORGE R. WARNER.

Tic Douloureux

Q.—Will you please send me the latest treatment for tic douloureux?—W. M. D., West Virginia.

A.—So far as I know, there has been no great change in the treatment of tic douloureux in the last few years. Alcohol injections are usually tried first and these are effective for a while, but the final resort is surgery.

Hardgrove[1] advocates treatment by the use of typhoid vaccine, and reports successful results in quite a number of cases treated by himself and others.

Some physicians in California reported a high percentage of successful results in treatment with massive doses of vitamin B_1. I am sorry that I do not have the reference for this treatment.—GEORGE R. WARNER.

Temporomandibular Joint

Q.—I am writing in regard to a patient of mine, a woman 31 years old, who has difficulty with the right side of her jaw.

When her mouth is open for any length of time, the right side of her jaw slips out of joint which leaves the jaw stiff and sore for several moments. Any excessive chewing on either side of the mouth seems to have this effect on the right side.

May I have your opinion in this case?—G. J. P., California.

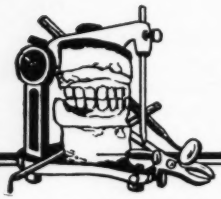
A.—The case presented in your letter is one of subluxation of the temporomandibular joint.

The treatment of these cases is ordinarily the application of hot epsom salt packs and the refraining from opening the mouth wide in yawning, laughing, or eating. Most cases recover in not too long a time.

One writer[2] advises the injection of a sclerosing solution around the joint. We have never found it necessary to resort to this treatment. — GEORGE R. WARNER.

[1]Hardgrove, T. A.: Tic Douloureux: Etiology, Accurate Diagnosis and Treatment by the Use of Typhoid Vaccine, J. A. D. A. **27**:507 (April) 1940.

[2]Schultz, Louis: A Curative Treatment for Subluxation of the Temporomandibular Joint or of Any Joint, Am. Ass. Jnl. & Den. Cosmos **24**:1947 (December) 1937.



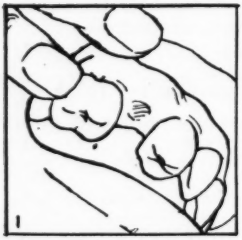
Technique of the Month

Conducted by W. EARLE CRAIG, D.D.S.

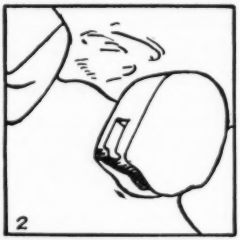
Drawings by Dorothy Sterling from sketches by the author

Securing an Accurate Impression of a Lug Seat for Fixed Bridge

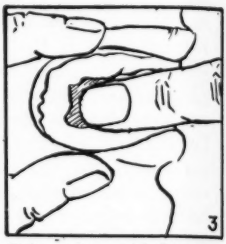
By Raymond K. Hyde, D.D.S.



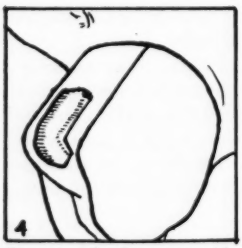
The case: replacing second bicuspid with a bridge which is attached to an MOD inlay in the first molar and rests on a lug seat in an MOD inlay in the first bicuspid.



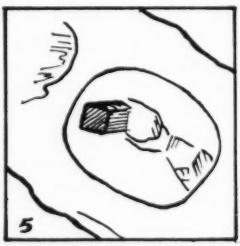
Prepare cavities. In carving the inlays, shape a lug seat on the distal of the first bicuspid. Cast. Cement the bicuspid inlay in place.



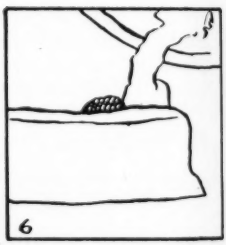
Take a bite with bite tray and wax.



True up the lug seat with stone or bur. Lubricate. Fill the lug seat with inlay wax, allowing the wax to extend beyond the cavity both occlusally and distally to permit it to be picked up in the impression.



Take impression in self-separating plaster. Note the accuracy of the impression of the lug seat.



Paint impression with separating medium. Pour the area around and over the wax in Diolite. Pour the rest of the impression in whatever material you prefer.

ANNUAL INDEX

Volume 38, 1948

ARTICLES

*Winner of the $100 ORAL HYGIENE prize award.

EDITORIALS

COST OF DENTISTRY UNDER BRITISH HEALTH SERVICE

THE DENTISTS have more strongly opposed the scheme of the National Health Service than the physicians. In a press interview, the Secretary of the British Dental Association states that 30,000 estimates for dental treatment are being received every day by the Dental Estimates Board and that the average cost is more than $20. This means that the scheme is now costing more than $600,000 a day, while the government estimate for a full year is only $28,000,000. This means that the scheme is costing more than seven times the government estimate. Many dentists have a large income, but the present scheme must break down sooner or later, and the Ministry of Health will be driven to a reconsideration of the whole matter. The Secretary claims that this result shows the wisdom of the policy of grant-in-aid advocated by the Association but rejected by the Ministry of Health. The Association is also demanding full clinical freedom and a guarantee that the Minister will not introduce a full-time dental service by regulation. At a meeting of the Council of the Association it has been decided to send a further letter to every member advising him not to enter the National Health Service.

The staggering increase of cost of the dental service is, of course, due to the offer of "something for nothing" which characterizes socialistic schemes. Everyone who can possibly do so wants to share in the spoils. It might be rejoined that the service is really not free, as the beneficiaries pay by their weekly contributions; but their payments amount to only part of the cost, the rest being made up by the state. In any case the

motive to share in the distribution remains exactly as if no contributions were made. This increased cost holds for all the industries that have been socialized. The cost of coal is more than doubled, and notwithstanding this, a loss has been made in the working of the industry. In state-owned industries no one has any interest in economy or efficiency.

Returning to the dentists, the Ministry of Health says that 7,000 have joined the service, but the Association states that almost the whole of this number can be accounted for by dentists who are not members of the Association.—*The Journal of the American Medical Association.*

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

Answers to Quiz LI

(*See page* 1921 *for questions*)

1. (a) 90 per cent. (Dingman, R. O., and Hayward, J. R.: Oral Surgery in General Practice, J.A.D.A. 35:623 [November] 1947)
2. (a) much faster than. (Tylman, S.D.: Crown and Bridge Prosthesis, St. Louis, C. V. Mosby Company, 1940, page 54)
3. Yes. (Skinner, E. W.: The Science of Dental Materials, 2nd Edition, Philadelphia, W. B. Saunders Company, 1941, page 158)
4. (b) 5.5—the value drops to about 4.1 on standing. (Accepted Dental Remedies, 13th Edition, Chicago, American Dental Association, 1947, page 51)
5. (b) putting points in mercury. (Grove, K. S.: Amalgam Technic, J. Colo. D. A. 25:9-15 [December] 1946)
6. (a) 22. (Robinson, Arthur: Cunningham's Textbook of Anatomy, 5th Edition, New York, Wood and Company, page 124)
7. True. (Accepted Dental Remedies, 13th Edition, Chicago, American Dental Association, 1947, page 149)
8. Yes. (Fuller, J. F.: Partial Denture Construction, New Zealand D. J. 43:117-132 [July] 1947)
9. (a) 0—1 millimeters. (Orban, Balint: Oral Histology and Embryology, 2nd Edition, St. Louis, C. V. Mosby Company, 1929, page 236)
10. (a) They appear dull gray in sunlight. (b) Under ultraviolet light they have a definite purple effect. (Tylman, S. D.: Crown and Bridge Prosthesis, 2nd Edition, St. Louis, C. V. Mosby Company, 1947, page 876)

Reprinted from APRIL, 1948 ISSUE

Justi-facts #75

DENTA PEARL | MUCO-SEAL

CYCLO-MOLD TEETH • JUSTI-TONE T-3 • FILM-AC

Fluorescent ACRYNAMEL, STAINS and ACCESSORIES

533. There is little logic in—

a) matching a natural tooth with a porcelain shade guide; then

b) matching the porcelain shade guide to an acrylic tooth (even if they are the same number); and then

c) expecting the acrylic tooth to match the natural tooth.

534. Use the Denta Pearl shade guide to match the natural tooth directly—there is a reason.

535. Denta Pearl shade guides are made—

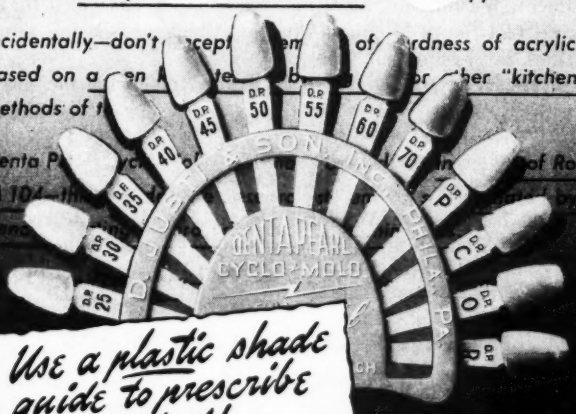
a) of the same shaded powders,

b) in the same machines,

c) by the same method, and at the same time . . . as Denta Pearl teeth—thus you have a direct match—not an approximation.

536. Incidentally—don't [illegible] of hardness of acrylic teeth based on a [illegible] or other "kitchen sink" methods of t[illegible]

537. Denta P[illegible] of Rockwell M 104—th[illegible] by inde[illegible]



Use a plastic shade guide to prescribe plastic teeth..... It's good appearance insurance!

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PATIENTS ON OUR FREE LIST

(*Continued from page* 1929)

that, while it is not being put on the books, when he gets over the present difficulties he can come in and settle his account. This gives the patient the feeling he is not accepting charity—and some of them *do* come in later.

No man should be niggardly, but there is a difference between being miserly and trying to play Santa Claus to everyone who enters the office with a hard-luck story, or with some letters trailing after his name.

There is truth in the story of the couple who were discussing a certain dentist. "Doctor Brown was a fine man," said one. "His fees were always so low, and half the time he didn't charge *me* at all."

"Me either," said the other. "And he worked so hard. Let's go out to the poorhouse and pay him a call."

VETERANS MAGAZINE MAIL RETURNED AS "FRAUDULENT"

IN ACCORDANCE with an order on file at the United States Post Office, Chicago, dated July 30, 1948, received from the Solicitor, Post Office Department, Washington, D. C., all mail matter addressed to Veterans Magazine, 624 South Michigan Avenue, Chicago, is being returned to the senders as "Fraudulent."

Dentists who are asked to subscribe to this magazine are hereby warned!

THE COVER

THE COVER features the American Dental Association Christmas Seal, the proceeds of which are used for the Relief Fund of the Association. Every practicing dentist is urged to support this worthy project.

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

Laffodontia

Student: "Could I try on that blue tweed suit in the window?"

Clerk: "We'd rather you'd use the dressing room."

★

At a large medical conference, one ambitious doctor leaned close to the one beside him and asked: "Where did Dr. Smith make his fortune?" The reply was brief. "Stork market!"

★

A golfer, trying to get out of a trap, said, "The traps on this course are very annoying, aren't they?"

"Yes," said the second golfer, trying to putt, "would you mind closing yours?"

★

Said one little nurse to another, "I've been eating an apple a day, but that new doctor still chases me!"

★

Of course there are some females of the species who are willing to give a man a way out. One such, after giving her boy friend a look into her past, said:

"Now that you know about my past, do you still want to marry me?"

"Sure thing," replied the boy friend.

"And I suppose," she said, "you will want me to live it down?"

"No, baby," he said, "I'll expect you to live up to it."

★

A retailer, annoyed because he had to wait several months for a large order, wired the manufacturer: "Cancel immediately."

Back came a wire: "Regret cannot cancel immediately. You must take your turn."

★

"Pa," said Hector, looking from the book he was reading, "what is meant by 'diplomatic phraseology'?"

"Well," replied Pa, "if you were to say to a homely girl, 'Your face would stop a clock,' that would be stupidity, but if you said to her, 'When I look into your eyes, time stands still,' that would be diplomatic phraseology!"

★

Voice from the rear of the cab: "Hey, driver, what's the idea of stopping here?"

Driver: "I thought I heard someone say 'stop!' "

Voice from the rear of the cab: "Drive on, she isn't talking to you."

★

She: "You're the kind of a man a girl cannot trust."

Student: "Haven't we met before? Your faith is familiar."

★

A dumb girl is a dope. A dope is a drug. Doctors usually give drugs to relieve pain. Therefore a dumb girl is just what the doctor ordered.

★

Caller: "I would like to see the Judge, please."

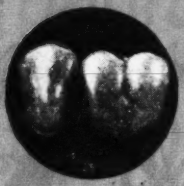
Secretary: "I'm sorry, sir, but he is at dinner."

Caller: "But, my man, my errand is important."

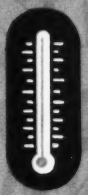
Secretary: "It can't be helped, sir. His honor is at steak."

STRAIN FREE

BETTER ANATOMY



More suitable for full and partial dentures



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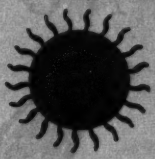
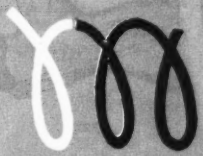


Permanent, non-fading fluorescence

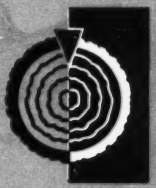
Here is why dentists and technicians prefer TRUBYTE ACRYLIC TEETH

BETTER BLEND OF SHADES



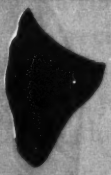
As lifelike as Trubyte New Hue Teeth

HARDER, DENSER



Grinds differently. Resists wear better

NATURAL SHADES



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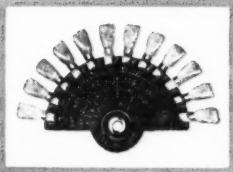
BETTER SHADES

Match Trubyte New Hue Shades accurately



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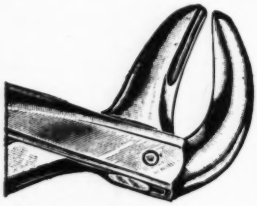

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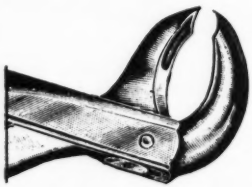

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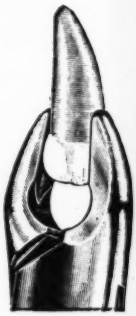

55

Hu-Friedy Forceps With Their Heritage of Quality and Efficiency

The forceps illustrated on this page have been designed and constructed in collaboration with authorities of oral surgeons and general practitioners and have been acknowledged as the most outstanding in their efficiency.

The beaks of all the forceps illustrated are built to fit the convexity of the root and eliminating contact with the crown of the tooth. The beaks will fit the topography of the root over a larger area, thereby distributing the pressure which will avoid breakage of the tooth. The two point contact has been eliminated.

Manufactured of *Immunity Steel,* properly balanced to reduce weight. The handles are so designed to render a firm and comfortable grip.

Other numbers available in addition to those illustrated are Nos. 150A, 151A, 62P, 214, 215, 6, 7 and 112.

Available through all dental supply houses.

HU-FRIEDY, INC.

3118 N. Rockwell St. • Chicago 18, Ill.

"Thank you, dear Doctor!"

Your patients will appreciate the visible benefits of Neutrox dentifrice.
Active Oxygen plus polishing agents in Neutrox combine to help improve the gingival tone . . . as well as clean and polish teeth thoroughly. Thus Neutrox really helps the tooth brush do a better job . . . remove surface stains from the teeth . . . leave the mouth in a cleaner, healthier condition.

MORE THAN ONE MILLION PACKAGES have been distributed, all as a result of original prescription or recommendation of dentists. Neutrox can be helpful in your practice, too.

Send for professional samples

DENTAL PRODUCTS DIVISION
VICK CHEMICAL COMPANY
122 East 42nd Street
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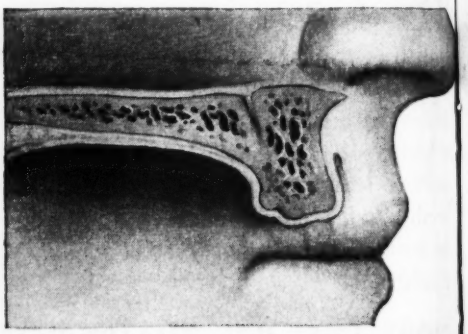
Special Problems in Denture Retention

Reproduction at the right is taken from the Wernet Booklet "Special Problems in Denture Retention" published for the dental profession.

Undercuts and Overgrowth of Tissue

Undercuts and overgrowth of tissue are often sou of denture trouble.[1] Large tuberosities may mak difficult to take a proper impression; and the pro nent points of undercuts on the ridges are apt to bruised by the denture.[37] Surgical removal of the b part may be unavoidable in some cases, but Mill believes that conservative management will be s cessful in many others.

Creeping, overgrowing tissues — unless surgic corrected — will require compensating reliefs in denture structure to protect folds, ridges and soft p from undue pressure... In the conservative mana ment of undercuts and/or overgrowth of tissue, re may be heightened, a better peripheral seal assur and denture efficiency materially improved, by t temporary use of Wernet's Powder.



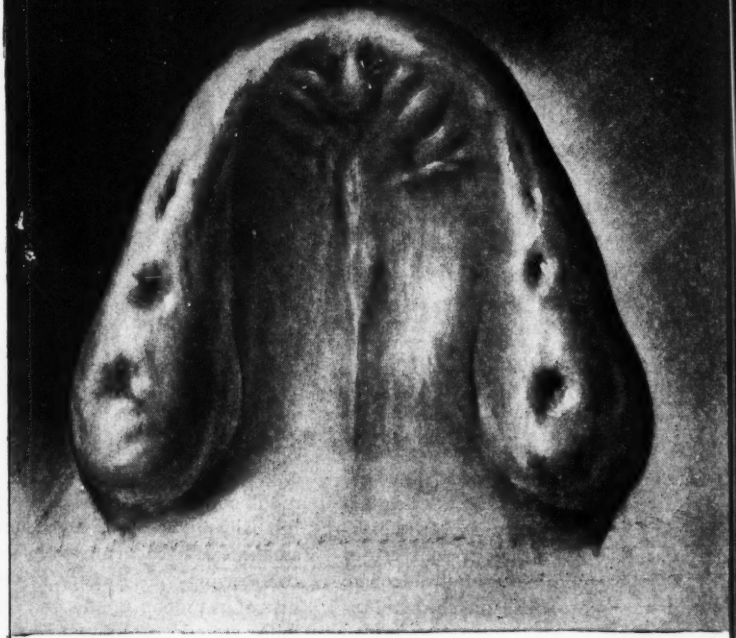
Cross-section of undercut.

10

Accepted
COUNCIL ON DENTAL THERAPEUTICS
AMERICAN DENTAL ASSOCIATION

WERNET'

BULBOUS TUBEROSITIES create undesirable undercuts endangering adequate peripheral seal.



To be protected against pressure, OVER-GROWTHS require reliefs in the denture.

IN THE PROBLEM OF

Maintaining Gingival Health

Deterioration in the integrity and functioning of gingival tissue occurring with advancing years, poses a perplexing problem in dentistry. In the absence of recognizable specific causes a well balanced dietary fully adequate in nutrient essentials therefore still appears to present the generally accepted favorable means for maintenance of gingival health and consequently, health of the dental structure.

Ovaltine in milk, a long established deliciously tasting dietary supplement, supplies all the nutrients considered essential for changing even fair diets to full nutrient adequacy. Three glassfuls daily provide the generous dietary amounts of nutrients listed in the accompanying table. Biologic completeness of its protein and the easy digestibility are other important features of this food supplement.

Ovaltine in milk is also useful in liquid diets, in those oral conditions when mastication and ingestion of solid foods are difficult or impossible.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

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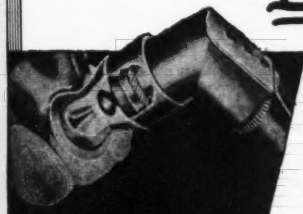
Makes the Big Difference!



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PATENTED RIBBED DESIGN Prevents Collapse

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Whether you use the Denticator Prophylactic Polishers on your regular handpiece—or on the

Streamlined Denticator Prophylactic Handpiece—

you are assured of

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An exclusive feature for thorough cleansing and polishing of the teeth.

You get:

★ SPEED
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★ ENDURANCE

when you use the polisher with the heavy Reinforcing Rib construction built right in the cup . . .

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Get an economical package from your Dental Dealer today! Ask for Denticator Prophylactic Polishers.

To try—send for free sample unit

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Real Savings For You!

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24 Hour Handpiece Repair Service


Akron, Ohio............56%
Devils Lake, N. Dak.73%
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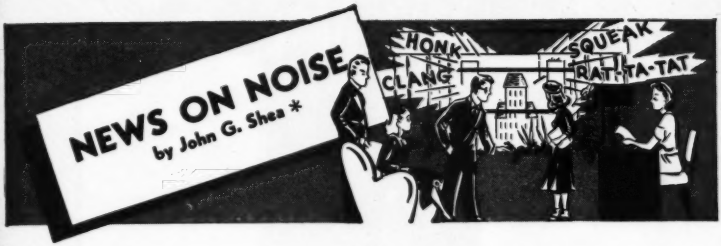
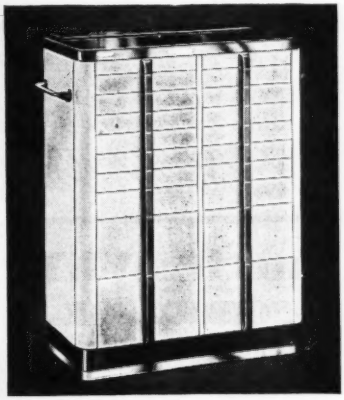


Your patients are extremely sound conscious . . . voices or routine noises from your operatory fill them with apprehension. You, yourself, will be able to work better if your office is free of the irritations of superfluous noise. Here's what to do:



The cabinet that's always in the right position — move it wherever you need it, American Mobile Clipper Cabinet No. 152.

Tight fitting doors and transoms of solid construction, insulated partitions . . . all will help to prevent noise and conversation from being overheard between adjoining rooms. In planning your office, keep the reception room apart by substantial walls or intervening hallways.

You can lower the general noise level by using carpets (laid over felt pads) and rubber and cork based flooring. Upholstered furniture and fabrics in the reception room, too, absorb noise.

A noisy dental cabinet, as well as being an eyesore, announces its antiquity with squeaking, rattling and banging drawers. Replace it with a silent *Modern American Cabinet.*

A *Modern American Dental Cabinet* makes your office look better, saves your time, and definitely contributes good news on control of noise. Send in the coupon for more information.

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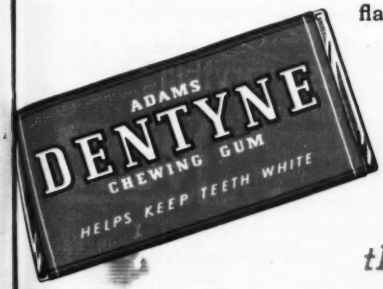
CITY AND STATE.....

lost pleasure regained...

with Dentyne Gum!

The consensus of acrylic denture wearers who have tried chewing Dentyne Gum is, "it's wonderful—and *different!*" Their new-found delight has been revealed in hundreds of letters telling us how easily and naturally Dentyne may be manipulated, *without fear of "sticking".* Dentyne's delicious flavor... extra resiliency... and freedom from adhesiveness make practice chewing for the new denture wearer a pleasurable experience. Of course, millions of persons with sound teeth chew Dentyne for its keen, long-lasting flavor and for the enjoyment it brings.



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CHEWING GUM

the ideal masticatory

your favorite form

for greater uniformity

Nothing can compare with the hydrocolloids for faithful reproduction of teeth and tissue . . . Dentists who have employed ALL types of impression materials in their search for the utmost precision will tell you that they prefer COE-LOID. Some of these men use COE-LOID POWDER; others choose COE-LOID 66.

Coe-Loid Powder, the alginate hydrocolloid, is simple and easy to mix. It is pure, smooth, and creamy. It registers microscopic detail. What's more, the material is strong and will not slump. Restorations fit when you use Coe-Loid Powder. And you can use it for partials, inlays and crowns, and static full dentures. Many recommend it also for immediate dentures.

Coe-Loid 66, the reversible thermoplastic hydrocolloid, is now made with pre-war agar. It has a heavy body and consequently remains in contact with high palates or deep undercuts recording every detail with great accuracy. For large, medium, or small full and partial dentures—and for orthodontia—Coe-Loid 66 is practical and pleasant.

For uniformly successful impressions choose Coe-Loid in your favorite form.

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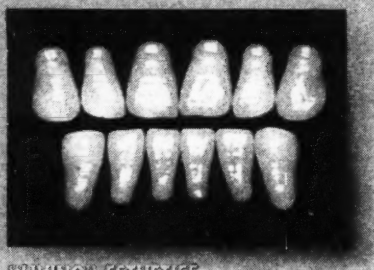
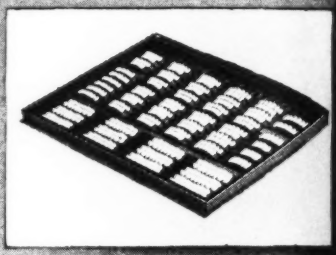


"LIVING" ESTHETICS

The labial characters and carvings of Five-Phase Anteriors reproduce *nature's* patterns.

***exclusive with* FIVE-PHASE ANTERIORS**



MOLD GUIDE—WITHOUT CHARGE

Your Universal Dealer will be glad to tell you how to get this valuable, complete Five-Phase Mold Guide, *without charge!* Call him for details—or write to us directly.

***exclusive with* UNIVERSAL DEALERS**

Doctor, your patients will appreciate your consideration of Five-Phase Anteriors. You will find the unmatched quality of Verichrome Porcelain and the "living" character of tooth carvings and colors far in advance of any other teeth presently available. They offer economical advantage too, since the price of Five-Phase Anteriors has not been increased.

FIVE

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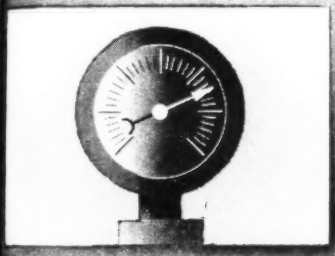
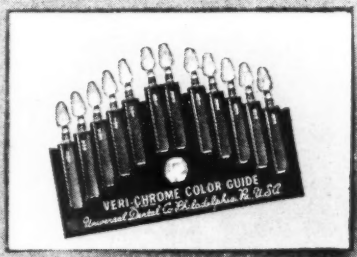
no increase in price!



STRONGEST PORCELAIN

You know by experience or certainly by reputation that famous Veri-chrome Porcelain is by far the strongest dental porcelain made—that it has the depth, refraction and translucency of human tooth structure.

exclusive with FIVE-PHASE ANTERIORS



NATURAL TOOTH COLORS

Veri-chrome Colors are *Natural Tooth Colors*—presented in a scientific system that helps you to match and select tooth colors expertly, quickly! Further, their color brilliance is controlled to assure harmony of blending with human teeth.

exclusive with FIVE-PHASE ANTERIORS

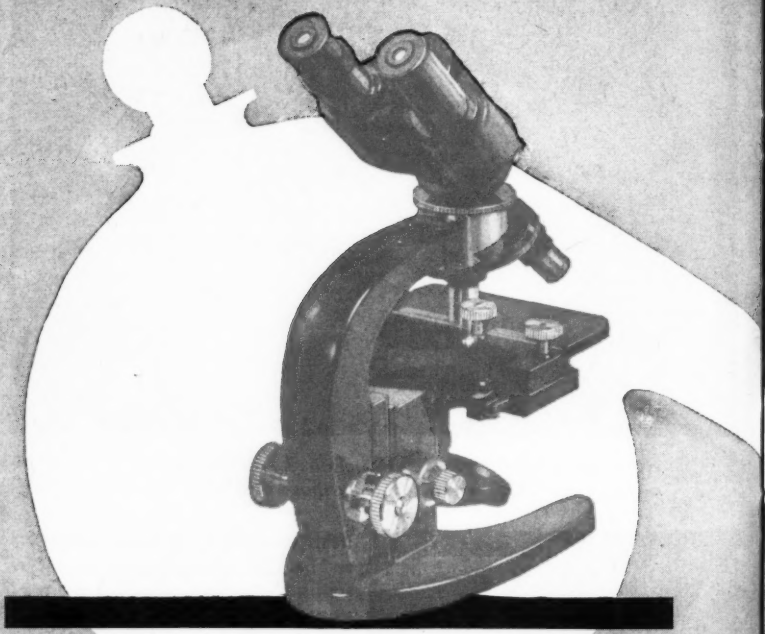
PHASE

ANTERIORS

MADE IN **Veri chrome** COLORS OF CONTROLLED BRILLIANCE

BROWN STREET, PHILA. 39, PA.

these are the facts abou



In cooperation with practicing Dentists, Baker research chemists standardized the setting time, control and shades of the improved Baker Filling Porcelain. Fillings definitely expand under moisture and seal margins after porcelain is set — there is much less than 1% disintegration when mixed to recommended putty-like consistency.

Be sure to mix to recommended thick consistency. Negligible minimum of free acid in Baker mix avoids pulp irritation. Baker Filling Porcelain complies with A.D.A Specification #9.

FILLIN

BAKER & CO., INC. • 850 PASSAIC AVE

ou super-porcelain . . .

Here, in this combination package is *everything* you need for perfect porcelain fillings.

With the new Baker non-metallic shade guide, only 8 natural tooth shades and four blending colors *are sufficient to match all tooth colors, accurately!* As a matter of fact, blending with the 4 basic colors is rarely required . . . in practically every case, you'll select one of the 8 natural tooth colors and allow the translucency of our porcelain and the reflection from surrounding tooth structure to complete the esthetic effect.

The combination package contains: 8 large bottles of Natural Tooth Shades; 4 half-portion Basic Colors; Baker non-Metallic Shade Guide; 4 Liquids; Thick glass slab; Stainless Steel spatula; 1 tube Baker Surface fixer; 1 Baker Cavity Liner and Lining Placer; 1 package wide celluloid strips; Davis Stainless Steel Matrix Material; Directions for Davis Technic and simplified Baker directions.

The complete combination package is available through all of the better dental depots.

RETAIL $30.00

N PORCELAIN

BAKER

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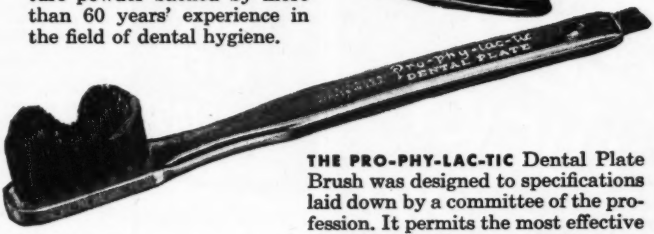
Help for your Denture Patients

PERMA-GRIP Adhesive Denture Powder can serve importantly to build your patient's self-confidence during the early stages of accommodation to a new denture. Perma-Grip provides exceptional holding power without danger of irritation to delicate tissues. It is made with high quality karaya gum and resists "balling up" under the denture. You can confidently recommend Perma-Grip, the *improved* denture powder backed by more than 60 years' experience in the field of dental hygiene.



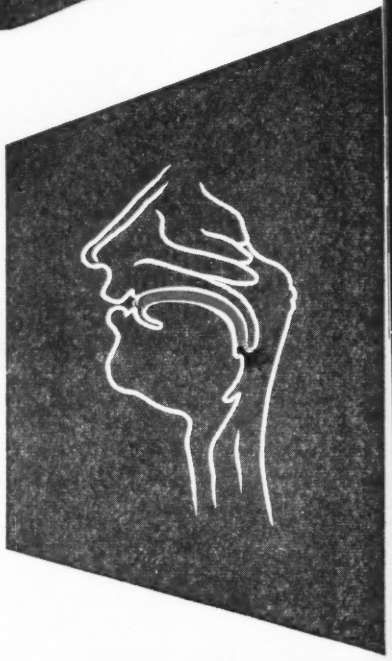
THE PRO-PHY-LAC-TIC Dental Plate Brush was designed to specifications laid down by a committee of the profession. It permits the most effective cleaning of *all* parts of the plate without danger of damage to clasps and attachments. Recommendation of a Pro-phy-lac-tic Dental Plate Brush will pay you dividends in extra good-will.

Pro-phy-lac-tic Brush Company
Florence, Mass.

LORAKON

COLLUTORY

setting a new trend in gently powerful oral therapy!



Used as a spray, mouth wash or rinse, ***LORAKON**** Collutory combines antisepsis with palliation in high degree. Clinical studies in a leading dental university indicate that it is beneficial and pleasant to use in oral conditions associated with dental surgery, peridontal disease and dental prosthetics. ***LORAKON*** apparently aids in the promotion of healing, and exerts no toxic or other undesirable after-effects. The incorporation of the strongly detergent, low-surface tension bactericide and fungicide, benzalkonium chloride U.S.P.—with glycerin U.S.P., imparts to ***LORAKON*** a desirably stable and prolonged antiseptic, detergent and deodorizing action. Possesses aromatic fragrance and pleasing taste. Supplied in 8 fluidounce and pint bottles.

LORAKON Collutory (in *in vitro* tests) is germicidal in 15 seconds against Staphylococcus aureus, Streptococcus hemolyticus, Corynebacterium diphtheriae, Diplococcus pneumoniae, Lactobacillus odontolyticus and Monilia albicans.

BAYBANK PHARMACEUTICALS, INC.
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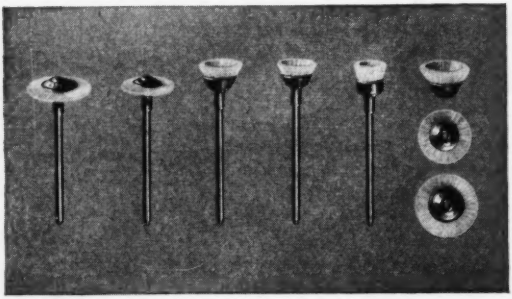
BAYBANK

*Trade-mark

BRUSH WITH THE ENDS OF THE BRISTLES

—like thousands of dentists who know that quick, painless, thorough prophylaxis

is PROFITABLE!



These dentists gladly pay a few cents premium to insure satisfied patients who will return again and again. They will buy only ROBINSON'S BRISTLE DISCS, the brushes that:

BRUSH WITH THE *ENDS* OF THE BRISTLES
— the normal action of revolving brushes

SAVE TIME
— because polishing action increases at the outer edge of a disc

PREVENT HEAT
— by requiring less pressure and dissipating heat, the cause of much discomfort

INCREASE THOROUGHNESS
— through easier cleaning of crevices and blind spots

ARE STERILE
— made from *sterilized* bristle

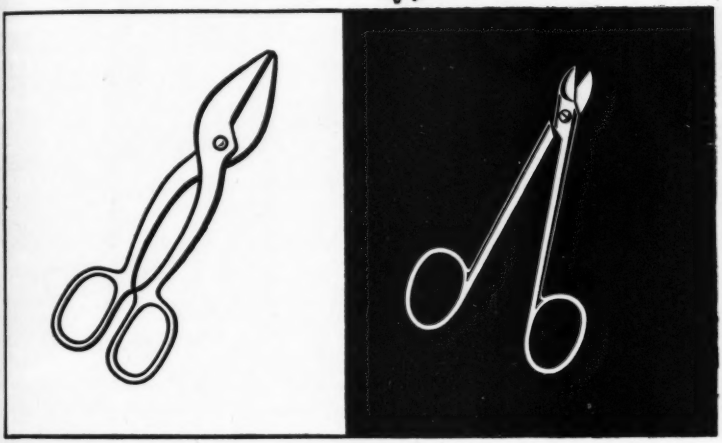
Genuine Robinson's Bristles Discs, manufactured only by Buffalo Dental, are unconditionally guaranteed against all defects. They are available from dental dealers everywhere. Prices: 1 doz., $1.00; 1 gross, $10.00; 3 gross, $27.00.

BUFFALO DENTAL
Manufacturing Co., Buffalo 3, N. Y.

NEARLY A CENTURY OF SERVICE TO THE DENTAL PROFESSION

DESIGN

makes a difference



These instruments are identical in basic mechanical principle. The difference is a matter of refinement—one of them has been specifically designed for a professional purpose.

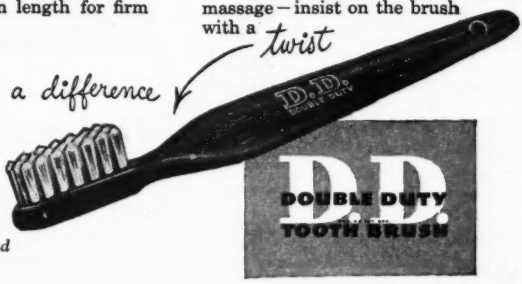
The D. D. Tooth Brush has been designed with the aid of a thousand practising dentists—

- A compact straight trim brush head, assuring easy access to tooth surfaces;
- Well-spaced bristle tufts for thorough brushing of interdental spaces;
- Springy long-life bristles that won't get soggy, ½ inch in length for firm brushing;
- A broad inflexible handle for maximum leverage, with a non-skid thumb rest;

and

- A new *twist* in the handle, which automatically encourages the desired up and down rotary motion for gentle gum massage. For Double Duty—thorough cleansing plus gentle gum massage—insist on the brush with a *twist*

DESIGN *makes a difference*



The D. D. Toothbrush is available with the popular two row bristle head as well as the larger three row type. Recommend the style best suited to your patient.

Product of BRISTOL-MYERS 19 West 50 Street, New York 20, N. Y.

That famous book—

Jackson's Orthodontia & Orthopaedia of the Face with Removable Appliances—may be reprinted if a sufficient number are interested. If you are, please register your name with Chester T. Sweet, 152 W. 42d St., New York 18, N. Y.

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MULTIPURPOSE,
RAPID SETTING,
FAST CURING,
PLASTIC

Fastcure
MULTIPAK

SAVES TIME! . . . .
NO HEAT NEEDED!

Yes . . . at last we can offer what you have always wanted—*a rapid setting, fast curing plastic:* for quick repairs; for relining; for individual impression trays and base plates; for the construction of immediate temporary dentures; etc., etc.

Simply . . . quickly . . . without the application of heat, *Acralite Fastcure Multipak* makes strong permanent repairs and additions . . . saving many minutes of valuable time in each application. Order Acralite's latest scientific achievement, through your dealer, today.

Fastcure Multipak is made by Acralite Co., Inc. pioneers in the development of dental acrylics!

Fastcure Package

Bottle of Liquid
Bottles of Powder (1 fine texture; 1 mottled texture)
Powder Graduate (each unit = 3CC.)
Liquid Dropper (marked for 1CC.)
Special Powder Bottle Cap (for alternative hand pressure packing technique)

Price $10

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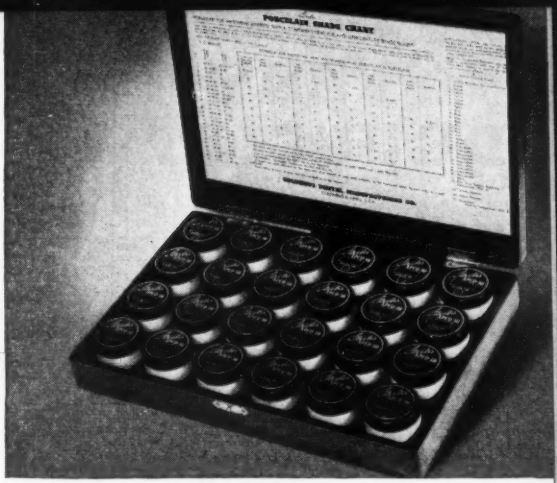
PRESTIGE

The prestige and wide acceptance which Bayer Aspirin enjoys was earned over a period of forty-seven years by always turning out the finest product of its kind that scientific skill can produce. Nothing you prescribe is made under more rigid controls. From raw materials to finished product over seventy different tests and inspections are employed. America's finest drug plant makes only one thing . . . *the* analgesic for home use . . . Bayer Aspirin.

Steele's

ANNOUNCE

APCO-HI



A new high fusing porcelain (matures at 2300°F) that *needs no mixing*. Saves time. Matches all New Hue shades accurately.

The colors of APCO-HI are factory blended to correspond with each of the twelve shades of the New Hue shade guide. There is a gingival body porcelain, and a translucent incisal porcelain for each New Hue shade. This greatly simplifies the problem for the dental Technician.

EXAMPLE: You wish to produce a crown to match New Hue shade 65. Select the jar of APCO-HI marked "Gingival—Shade 65" and that marked "Incisal—Shade 65." A combination of these two porcelains will accurately match New Hue shade 65.

APCO-HI is now available at your supply house in ¼ oz., ½ oz., 1 oz., ¼ lb., ½ lb. and 1 lb. jars. Also in standard assortments of 24 half ounce or quarter ounce jars.

Steele's

APCO-HI
(matures 2300°F)
and
APCO
(matures 1875°F)

These two porcelains now cover every requirement in the Dental Ceramic field. Both porcelains have physical properties that are outstanding. Note: The regular APCO porcelain (maturing at 1875°F) is not at present factory blended like new APCO-HI.

EVERY DRUGGIST

now has Craig-Martin

TOOTH PASTE

—or can get it through his jobber

Bears the Seal of Acceptance of the Council on Dental Therapeutics of the American Dental Association.

You can suggest this economical, efficient tooth paste to your patients, knowing that it is now available or can be readily supplied by any druggist you name.

10¢ Large Size
33¢ Giant Size

LARGE 10c TUBE

shown actual size

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3 Popular Sets:
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Complete with Paints, Brushes, Etc.
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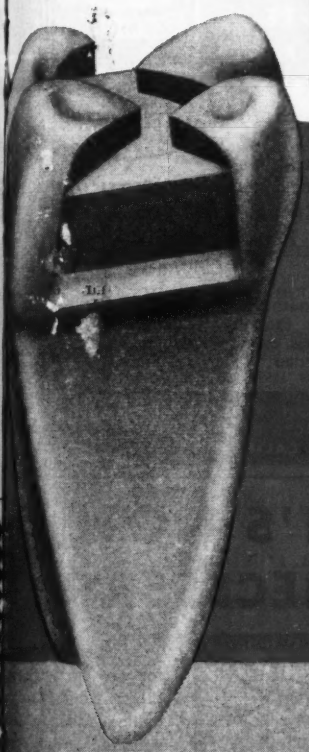
This Jar saves time & money

the M.O.D. presents a problem that DIAFIL answers effectively!



How frequently the M.O.D. patient rebels at the idea of a posterior restoration which glaringly betrays its presence when the mouth is opened wide. To singers, speakers and others in public life, esthetics are of prime importance.

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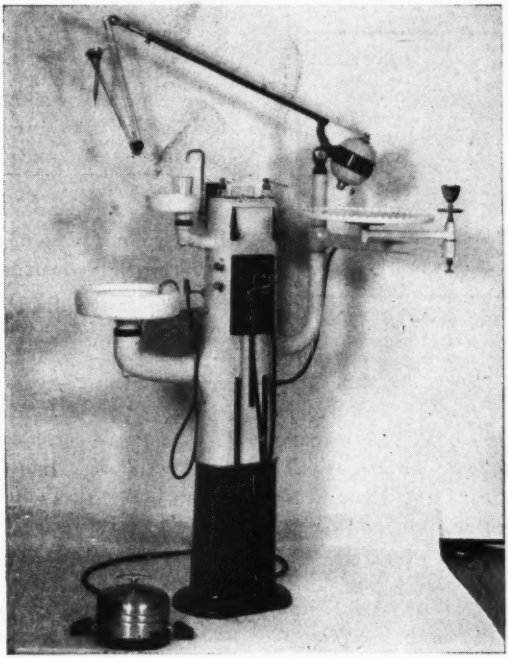

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Another Reprinting . . . . Total Now Printed

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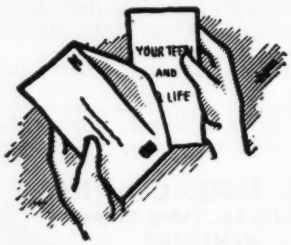
One practitioner in Georgia has ordered 100 *copies of "Your Teeth and Your Life" every month since February* 1943!

The continued demand for "Your Teeth and Your Life" has necessitated another reprinting. Copies now printed total *one-half million.* Actual sales total over four hundred thousand copies.

If you are not using this ethical patient-education material in your practice may we urge you to do so now? It is written and illustrated so that your patients can readily assimilate its message . . . *the value of periodic dental care and the dangers of neglect.* One practitioner writes: "Your booklet entitled *Your Teeth and Your Life* is one of the finest pieces of literature for the patient that I have come across. In fact I think so much of it that I am mailing it to my patients regularly."—H. A. T., Philadelphia. This is a typical comment . . . it is the rule rather than the exception.

"Your Teeth and Your Life" can be used in many ways in *your* practice: (1) in the reception room; (2) as a statement enclosure; (3) for patients upon dismissal; (4) distribution to Parent-Teacher groups; (5) distribution to children by school dentists; (6) enclosure with patient recall cards.



Ethical patient-education material of this high type is worthy of distribution in your practice. Why not order a supply now? The cost is negligible.

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TOPI-FLUOR WAX IMPRESSION METHOD OF APPLICATION

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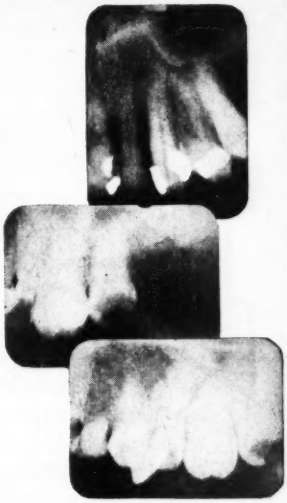

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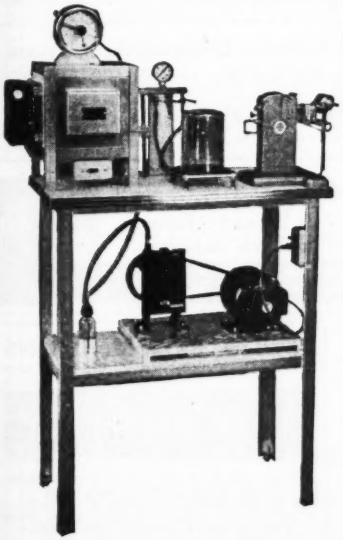

Includes a 3-way manifold with vacuum gauge—one connection for the casting machine, one for the bell jar and one for any desired purpose. The electric furnace has a unique thermostat which *maintains any set temperature INDEFINITELY.*

The combination of vacuum with centrifugal force makes truly amazing castings—much *finer margins* and far greater *detail*—dental castings could never before be made as *dense*. This equipment is hailed the greatest advancement in casting technic in many years—AND, neither special casting rings nor special investing technic are needed! The bell jar is included for those who want it—but it is *not* a prerequisite to vacuum casting. The outfit is available complete—or you may obtain the individual parts separately.

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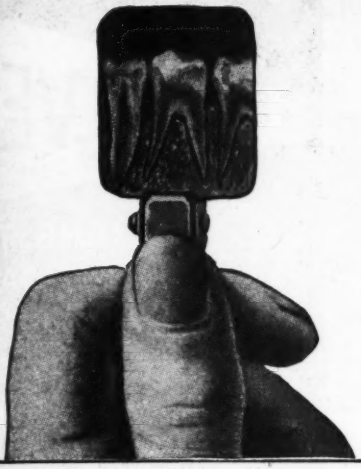

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Available in moisture-proof vials or in bulk -- in 1000 or 5000 units.

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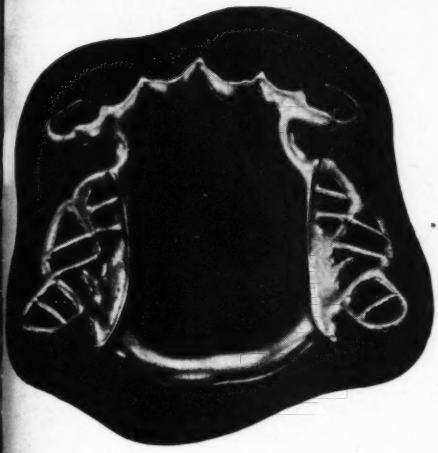

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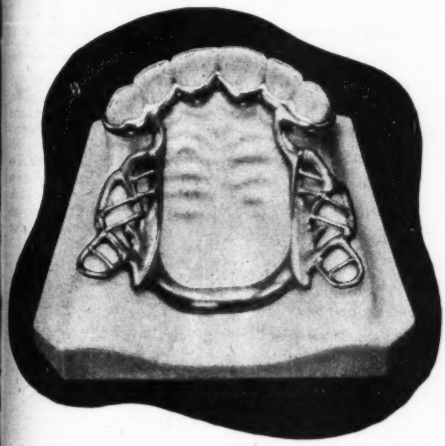

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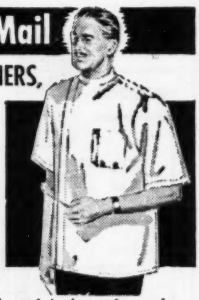

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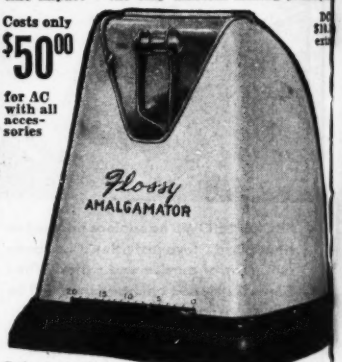

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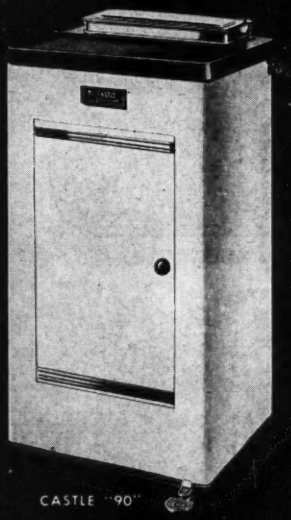

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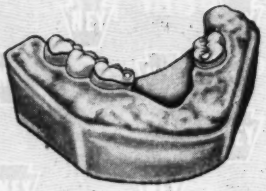

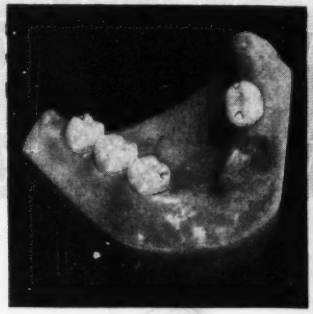

TECHNICALLY SPEAKING . . .

At zero tilt (with the model held in the level occlusal plane) the right molars showed very severe lingual undercuts and none at all on the buccal. Consequently it required a pronounced right lateral tilt to develop the buccal undercuts needed for retention with the #1 clasps that were being planned for that side of the denture. A slight posterior tilt was then introduced in order to produce non-undercut areas on the mesial of the first molar and at the distal of the third.

At this tilt the left molar abutment presented sharply undercut lingual and mesial surfaces. There is some undercut at the mesio-buccal as well, but the survey line is low enough to allow the rigid shoulder of a ring clasp to be placed above it without interfering with the opposing teeth. Of course the mesial undercut must be relieved to allow the truss arm to seat without interference.

The four accompanying drawings show different views of the model with survey lines and resultant undercuts at the tilt which was used in designing and making this case.

Number twenty-six of a series

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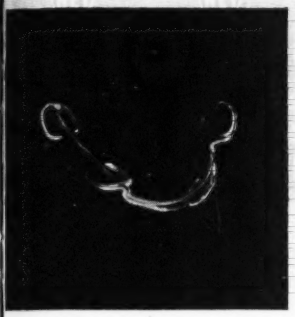

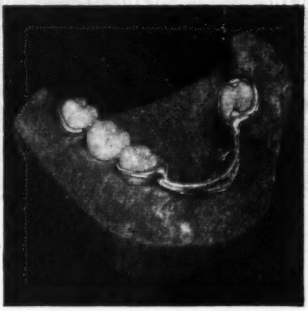

THIS was another one of those unfortunate war injuries caused by a machine gun bullet. It resulted in the loss of all the lower anteriors and bicuspids plus the lower left first molar. A major problem was to plan clasps for the restorative appliance which would supply the best possible bracing *within themselves*, inasmuch as the destruction and loss of tissue prevented the saddle area from being of any material help in stabilizing the denture. Therefore it was decided to rely on the right side with its molar teeth in good condition for the main bracing function and to try to develop satisfactory #1 clasp indications there.

Thorough planning and sound application of Ney Surveyor principles gave this patient a partial denture which has restored his mouth to normal function and which, at the same time, will help to prolong the life of his few remaining teeth. This last is especially important since the abnormal bone and tissue loss would make the wearing of a full denture difficult, if not impossible.

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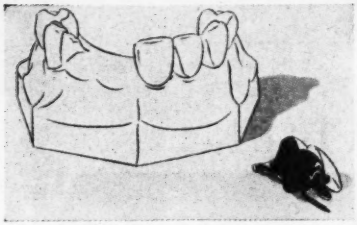

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When aesthetic value is of great importance, Seabrook Attachments insure superior results. Metal clasps are used only on the *lingual surface*. Attachments are held firmly by a small tube containing a helix wire which exerts a slight pressure on the adjacent tooth. Use of crowns or inlays is eliminated. Seabrook Attachments are removable and easy to keep clean.

Use of Seabrook Attachments eliminates difficult technique. A descriptive folder outlining directions for best results is enclosed with every order.

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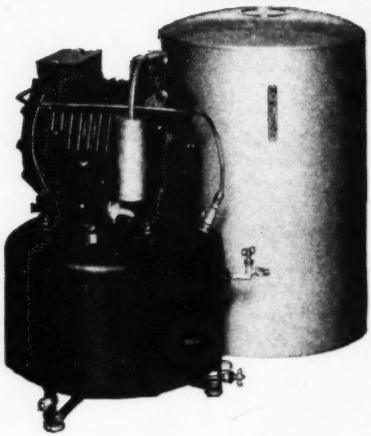

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different from all others . . .

Because TUCiDOR is *always a fresh solution* . . . remains at the most effective percentage and pH indefinitely.

Because a *stable* solution is always dependable.

Because the special container is *not affected* by sodium fluoride.

***Safe* . . . *Non-irritating* in contact with gingival tissues . . . *No contra-indications* . . . Simple technic.**

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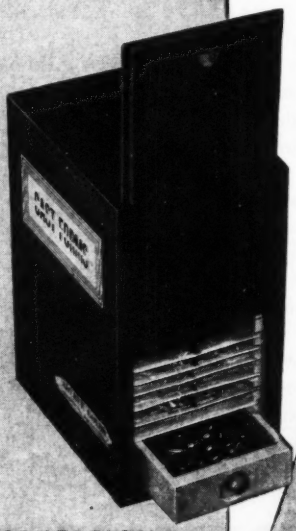
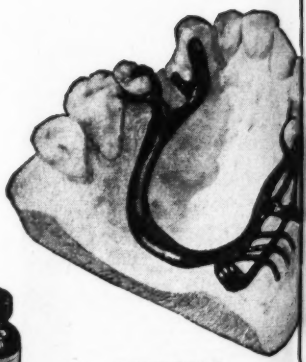
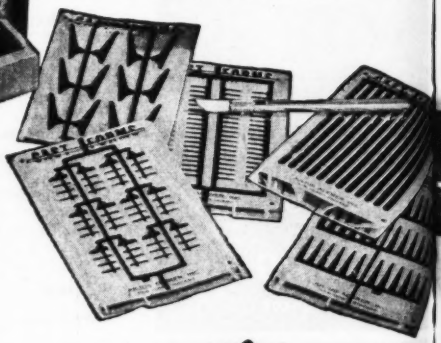




A TYPICAL CAST FORM ASSEMBLY



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VALUE	$19.50
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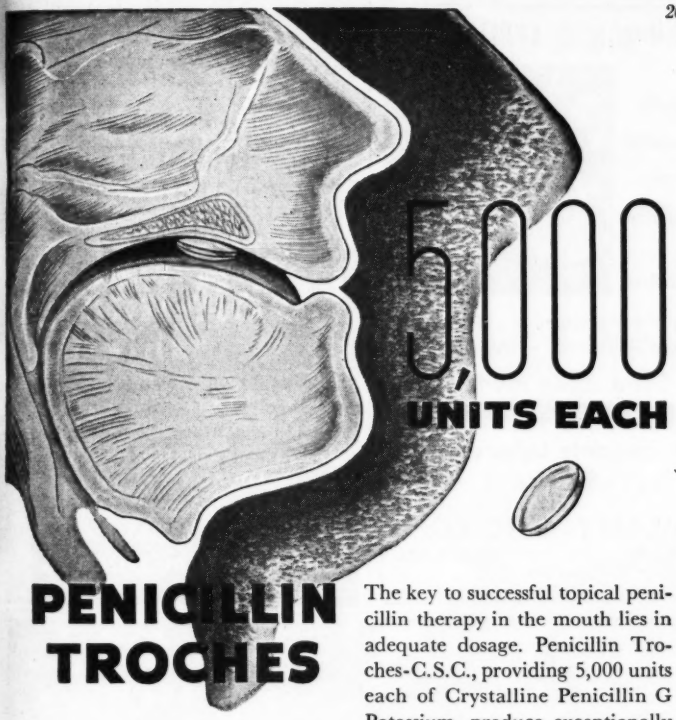

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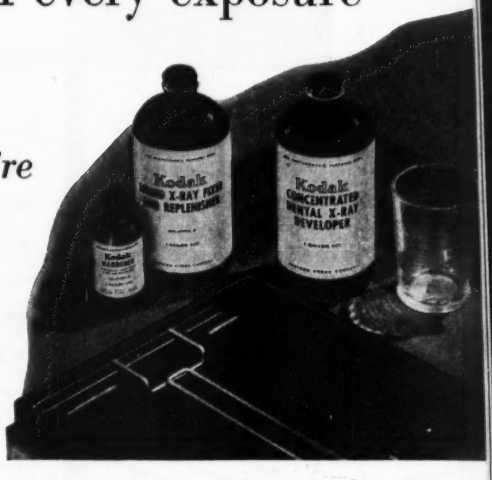

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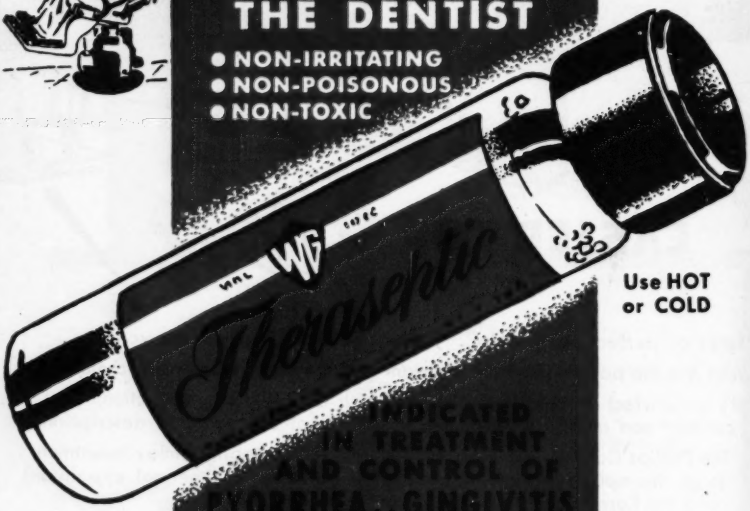

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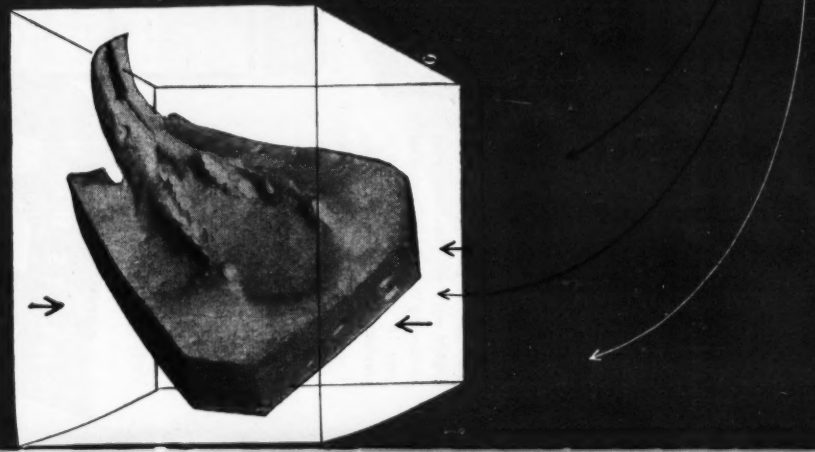

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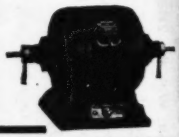

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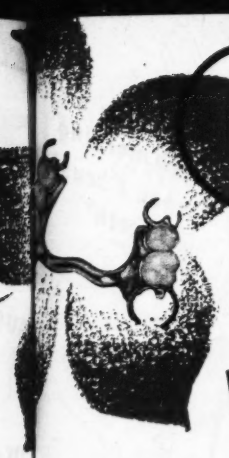

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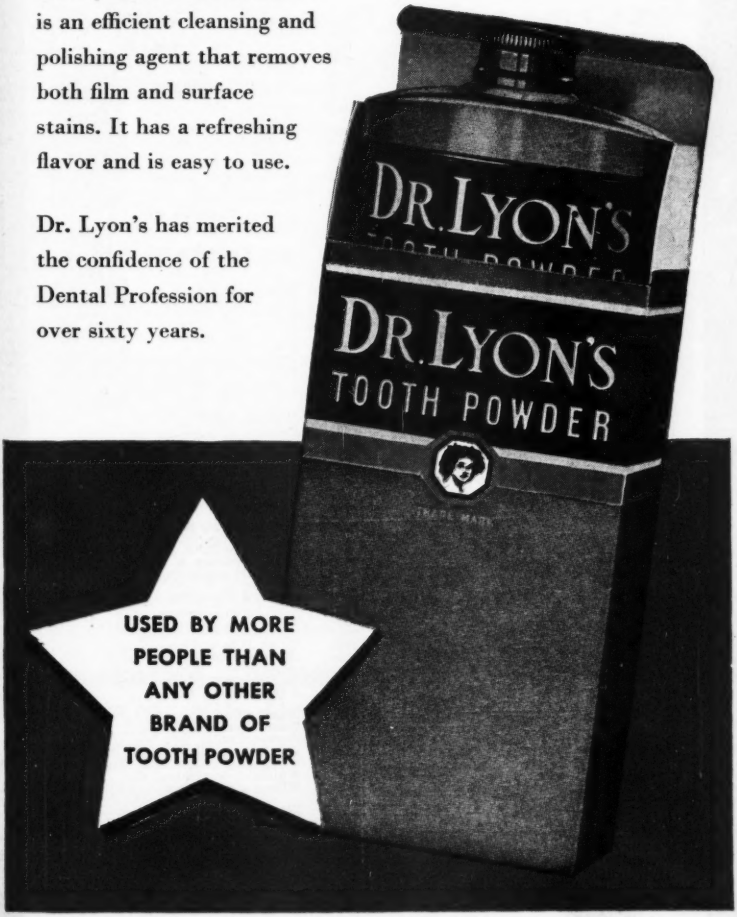

ADVERTISING INDEX

WHO'S WHO AND WHERE

Although we aim for accuracy in this index, last-minute changes often alter page numbers and positions

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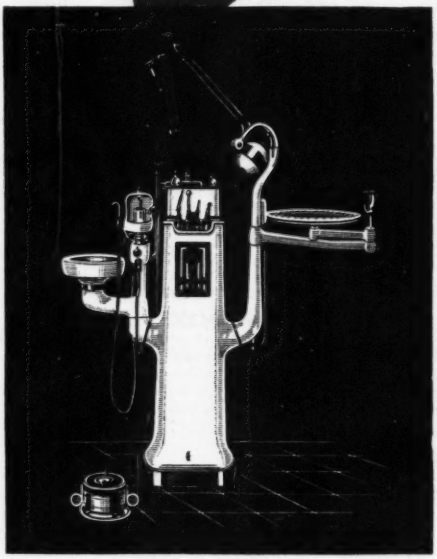

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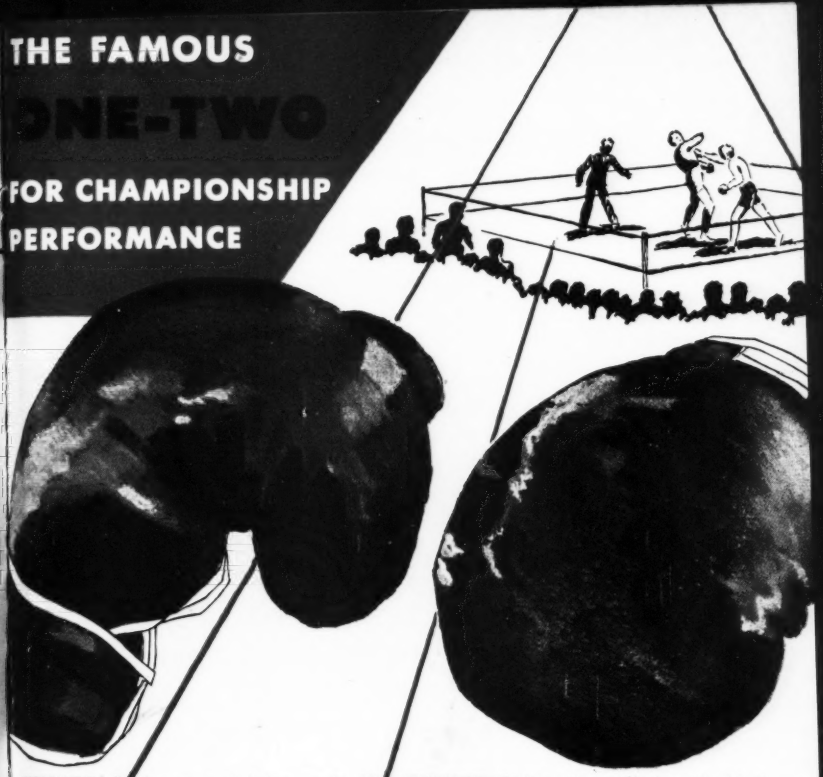

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